

Family Planning Services Provider Manual



**Iowa Department
of Human Services**



Iowa
Department
of Human
Services

Provider
Family Planning Services

Page
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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. FAMILY PLANNING CLINICS ELIGIBLE TO PARTICIPATE

Family planning clinics that are approved by the Iowa State Department of Public Health and are under the direction of a physician are eligible to participate in the Medicaid program.

B. COVERAGE OF SERVICES

Covered services include counseling, medical examinations, laboratory tests, and drugs and supplies furnished by the clinic in connection with family planning. Family planning services include the following:

- ◆ Examination and tests that are necessary before prescribing family planning services.
- ◆ Contraceptive services. (Sterilization procedures must meet the informed consent requirements as outlined in this manual.)
- ◆ Supplies for family planning, including such items as an IUD, a diaphragm, or a basal thermometer.

1. Excluded Services

Services performed for abortions, childbirth, or the treatment of an illness or injury that have a secondary family planning relationship are not considered as family planning services. Do not mark these claims as family planning-related services.

Reversals of sterilization procedures are not covered procedures.

2. Restrictions on Sterilization

“Sterilization” means any medical procedure, treatment, or operation for the purpose of rendering a person incapable of reproducing that is not:

- ◆ A necessary part of the treatment of an existing illness; or
- ◆ Medically indicated as an accompaniment to an operation of the genitourinary tract.



Mental illness or retardation is not considered an illness or injury for the purpose of this definition.

Federal regulations provide that Medicaid payment shall not be made for sterilization of a person who is under 21 at the time of consent or who is legally mentally incompetent or institutionalized.

A "legally mentally incompetent" person is a person who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the court declares the person competent for purposes that include the ability to consent to sterilization.

An "institutionalized" person is a person who is:

- ◆ Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
- ◆ Confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

Medicaid payment may be made for the sterilization of a person age 21 or over when informed consent is given, if the person is mentally competent and not institutionalized in accordance with the above definitions. All of the following conditions must be met:

- ◆ The person to be sterilized must voluntarily request the services.
- ◆ The person to be sterilized must be advised that the person is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing future care or loss of other project or program benefits to which the person might otherwise be entitled.
- ◆ The person to be sterilized must be given an explanation of the procedures to be performed by a knowledgeable informant, upon which the person can base the consent for sterilization. If the person is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided.
- ◆ The person to be sterilized must sign an "informed consent" to the procedure. (See [Consent for Sterilization, 470-0835 and 470-0835S.](#)) The person must be 21 years of age or older at the time of consent.



“Informed consent” means the voluntary knowing assent from the person on whom the sterilization is to be performed after the person has been given a complete explanation of what is involved and has signed a written document to that effect.

The person to be sterilized may be accompanied by a witness of the person’s choice. The informed consent shall not be obtained while the person to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substance that affects the person’s state of awareness.

The elements of explanation that must be provided are:

- ◆ A thorough explanation of the procedures to be followed and the benefits to be expected.
- ◆ A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
- ◆ Counseling concerning appropriate alternative method of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure.
- ◆ An offer to answer any inquiries concerning the proposed procedures.

The “informed consent” must be obtained at least 30 days but not more than 180 days before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs.

When emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent form was obtained for the exception to be approved.

When a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained. Documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed for the exception to be approved.



3. Consent for Sterilization, 470-0835 and 470-0835S

For a sterilization to be Medicaid-payable, an “informed consent” shall be obtained on:

- ◆ *Consent for Sterilization*, form 470-0835 or 470-0835S, or
- ◆ An official sterilization consent from another state’s Medicaid program that contains all the information found on the Iowa form, and complies with all applicable federal regulations.

To view a sample of Iowa’s English consent form on line, click [here](#). To view a sample of the Spanish consent form on line, click [here](#). A supply of the form may be obtained from the IME Provider Services Unit on request.

All names, signatures and dates on the consent form must be fully, accurately, and legibly completed. The only exceptions are:

- ◆ The “Interpreter’s Statement” is completed only if an interpreter is actually provided to assist the patient to be sterilized.
- ◆ The information requested pertaining to race and ethnicity may be supplied voluntarily on the part of the patient, but is not required.

It is the responsibility of the person obtaining the informed consent to verify that the patient requesting the sterilization is at least 21 years of age on the date that the patient signs the form. If there is any question pertaining to the true age of the patient, the birth date must be verified.

The “Statement of Person Obtaining Consent” may be completed by any qualified professional who is capable of clearly explaining all aspects of sterilization and alternate methods of birth control available to the patient.

The “Physician’s Statement” must be fully completed and be signed by the **physician performing the sterilization**. One of the paragraphs at the bottom of this statement must be checked. Be sure to cross out the paragraph that does not apply to the situation. If paragraph two is appropriate, indicate the expected date of delivery and the circumstances involving emergency abdominal surgery.

The only signatures on the completed consent form should be those of:

- ◆ The patient,
- ◆ The interpreter, if interpretation services were provided,
- ◆ The person obtaining the consent, and
- ◆ The physician performing the sterilization.



Since the physician performing the sterilization is the last person to sign the form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization that will submit a claim (hospital, anesthetist, assistant surgeon, etc.).

It is the responsibility of the hospital and other providers associated with the sterilization services to obtain a photocopy of the complete consent form, which must be attached to their claims when submitted to the IME for payment.

The physician's copy of the *Consent for Sterilization*, 470-0835 or 470-0835S, must be completely executed in all aspects according to the directions above and must be attached to the claim in order to receive payment.

When a claim for physician's services for sterilization is denied, any claim submitted by the hospital, anesthesiologists, assistant surgeon, or associated providers for the same operation or procedure will also be denied. This includes denials due to:

- ◆ Failure to have the consent form signed at least 30 days and not more than 180 days before the date service is provided, or
- ◆ Failure to use the official consent form.

C. BASIS OF PAYMENT FOR FAMILY PLANNING SERVICES

The basis of payment for family planning services is a fee schedule established by the Department based on the physician fee schedule.

D. PROCEDURE CODES AND NOMENCLATURE

Iowa uses the HCFA Common Procedure Coding System (HCPCS). HCPCS codes are divided into three levels. Level 1 is the current CPT-4 codes. Levels 2 and 3 are specifically designed regional and local codes (five-digit codes beginning with alphabetical characters A or B). Level 3 also includes codes beginning with alphabetical characters from W-Z (local).

Claims submitted without a procedure code and appropriate ICD-9-CM diagnosis code will be denied.



1. Supplies

<u>Code</u>	<u>Description</u>
J7300	Intrauterine device
J7303	Contraceptive supply, hormone containing vaginal ring, each
S4989	Progestasert intrauterine device
A4267	Condom, nonspermicidal
A4267	Condom, spermicidal
A4268	Female condom
A4269	Contraceptive foam
A4269	Contraceptive jelly
A4269	Contraceptive cream
A4269	Spermicidal suppositories
A4269	Vaginal contraceptive film
A4269	Contraceptive sponges
A4261	Cervical caps
A4266	Diaphragm
A4932	Basal thermometer
11975	NORPLANT implantation (includes the cost of the product NORPLANT) *
11976	Removal of NORPLANT implant *
11977	Removal with reinsertion of implantable contraceptive capsule
T1999	Supplies and materials provided by physician over and above normal services

* No office visit shall be billed in addition to these codes.

2. Drugs

<u>Code</u>	<u>Description</u>
S4993	Oral contraceptive, 21-day supply
S4993	Oral contraceptive, 28-day supply
J3490	Doxycycline
J3490	Flagyl
J3490	Vaginal cream (i.e., Terazol)
J1055	Depo-Provera for contraception
90782	Injection administration



3. X-Ray and Laboratory Services

Procedure code 99000 is a specimen handling and collection fee. This procedure can be billed only one time per date. It must be used when an outside laboratory is performing the analysis.

<u>Code</u>	<u>Description</u>
76815	Diagnostic ultrasound limited (not covered under IFPN)
81000	UA by reagent strips
81001	UA, auto with scope
81002	UA, routine without microscopy
81003	UA, auto without scope
81025	Urine pregnancy test
82948	Glucose, blood, stick test
84703	Gonadotropin, qualitative (pregnancy test)
85004	Automated differential white blood cell count
85007	Differential white blood cell count
85013	Hematocrit
85014	Blood count, hematocrit
85018	Blood count, hemoglobin
85025	Automated hemogram with differential white blood cell count
85027	Automated hemogram
86318	Immunoassay for infectious agent reagent strip
86580	Tuberculosis, intradermal (not covered under IFPN)
87102	Knickers test for yeast
87110	Culture, Chlamydia
87205	Smear, primary source, with interpretation, routine
87210	Smear, primary source, with interpretation, wet mount
87211	Smear, primary source, with interpretation, wet/dry mount
87220	Koh test
87491	Chlamydia trachomatis, amplified probe technique
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
99000	Laboratory collection and handling fee
99001	Handling and conveyance of specimen for transfer from patient to other than physician's office to a lab (distance may be indicated)
99002	Handling, conveyance and other service in connection with the implementation of an order involving devices when devices are fabricated by an outside lab but which items have been designated, and are fitted and adjusted by the attending physician.



4. Office Services

a. Office Services: New Patient

<u>Code</u>	<u>Description</u>
99201	Office or other outpatient visit, requires: <ul style="list-style-type: none">• a problem-focused history,• a problem-focused examination, and• straightforward medical decision making.
99202	Office or other outpatient visit; requires: <ul style="list-style-type: none">• an expanded problem-focused history,• an expanded problem-focused examination, and• straightforward medical decision making.
99203	Office or other outpatient visit; requires: <ul style="list-style-type: none">• a detailed history,• a detailed examination, and• medical decision making of low complexity.
99204	Office or other outpatient visit; requires: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination, and• medical decision making of moderate complexity.
99205	Office or other outpatient; requires: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination, and• medical decision making of high complexity.

b. Office Services: Established Patient

<u>Code</u>	<u>Description</u>
99211	Office or other outpatient visit; may or may not require the presence of a physician.
99212	Office or other outpatient visit, requires at least two of these three components: <ul style="list-style-type: none">• a problem-focused history,• a problem-focused examination, and• straightforward medical decision making.
99213	Office or other outpatient visit; requires at least two of these three components. <ul style="list-style-type: none">• an expanded problem-focused history,• an expanded problem-focused examination, and• medical decision making of low complexity.



<u>Code</u>	<u>Description</u>
99214	Office or other outpatient visit; requires at least two of these three components: <ul style="list-style-type: none">• a detailed history,• a detailed examination, and• medical decision making of moderate complexity.
99215	Office or other outpatient visit; requires at least two of these three components: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination, and• medical decision making of high complexity

c. Preventive Medicine Services: New Patient

Use the modifier GN for services to members aged 20 or under.

<u>Code</u>	<u>Description</u>
99383	Initial evaluation and management of a healthy individual, late childhood (age 5 through 11 years), requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factors, and• the ordering of appropriate laboratory and diagnostic procedures.
99384	Initial evaluation and management of a healthy individual, adolescent (age 12 through 17 years), requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factors, and• the ordering or appropriate laboratory and diagnostic procedures.
99385	Initial evaluation and management of a healthy individual, age 18 through 39 years, requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factor, and• the ordering of appropriate laboratory and diagnostic procedures.
99386	Initial evaluation and management of a healthy individual, age 40 through 64 years, requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factors, and• the ordering of appropriate laboratory and diagnostic procedures.



d. Preventive Medicine Services: Established Patient

Use the modifier GN for services to members aged 20 or under.

<u>Code</u>	<u>Description</u>
99393	Periodic reevaluation and management of a healthy individual, late childhood (age 5 through 11 years), requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factors, and• the ordering of appropriate laboratory and diagnostic procedures.
99394	Periodic reevaluation and management of a healthy individual, adolescent (age 12 through 17 years), requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factors, and• the ordering of appropriate laboratory and diagnostic procedures.
99395	Periodic reevaluation and management of a healthy individual, age 18 through 39 years, requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factors, and• the ordering of appropriate laboratory and diagnostic procedures.
99396	Periodic reevaluation and management of a healthy individual, age 40 through 64 years, requiring: <ul style="list-style-type: none">• a comprehensive history,• a comprehensive examination,• identification of risk factors, and• the ordering of appropriate laboratory and diagnostic procedures.
99429	Unlisted preventive medical services (not covered under IFPN)

e. Other Services

<u>Code</u>	<u>Description</u>
99420	Administration and interpretation of health risk assessment instrument (e.g. health hazard appraisal)
99420	Completion of Risk Assessment Form



5. Surgical Services

<u>Code</u>	<u>Description</u>
55250	Vasectomy unilateral or bilateral (not covered under IFPN)
55300	Vasotomy for vasograms (not covered under IFPN)
56420	Incision and drainage of Bartholin's gland abscess (not covered under IFPN)
56501	Destruction of lesions in the vulva, simple (not covered under IFPN)
56515	Destruction of lesions in the vulva, extensive (not covered under IFPN)
56600	Biopsy of vulva (not covered under IFPN)
57170	Diaphragm fitting and instruction
57180	Introduction of hemostatic agent (not covered under IFPN)
57452	Colposcopy (vaginocopy) (not covered under IFPN)
57454	Colposcopy with biopsies (not covered under IFPN)
57500	Biopsy, single or multiple, or excision of lesion (not covered under IFPN)
57505	Endocervical curettage (not covered under IFPN)
57510	Cauterization of cervix, electric or thermal (not covered under IFPN)
57511	Cauterization of cervix, cryocautery (not covered under IFPN)
57513	Cauterization of cervix with laser ablation (not covered under IFPN)
57520	Conization of cervix, with or without fulguration (not covered under IFPN)
58100	Endometrial biopsy, suction type (not covered under IFPN)
58300	Insertion of intrauterine device
58301	Removal of intrauterine device
58600	Ligation or transection of fallopian tubes, abdominal
58605	Ligation or transection of fallopian tubes, postpartum (not covered under IFPN)
58611	Ligation or transection of fallopian tubes, during C-section
58615	Occlusion of fallopian tubes by device
58982	Laparoscopy, surgical with fulguration of oviducts (not covered under IFPN)



6. Immunizations

Provide immunizations under the Vaccines for Children Program (VFC). Immunizations are usually given in conjunction with a medical service. Immunization procedures include the supply of related materials. Bill code W0782 for vaccine administration in addition to the CPT code and modifier. For VFC vaccine, the charges in box 24F should be "0."

<u>Code</u>	<u>Description</u>
90745	Hepatitis B vaccine; 11-19 years (not covered under IFPN)
90746	Hepatitis B vaccine; 20 years and above (not covered under IFPN)

Modifiers indicating the dose of vaccine in the series are required. Claims will be denied when a modifier is not present on the claim form.

<u>Modifier</u>	<u>Description</u>
01	First dose
02	Second dose
03	Third dose
04	Fourth or more doses

When a patient receives a vaccine outside of VFC coverage, Medicaid will provide reimbursement.

E. ELIGIBILITY UNDER THE IOWA FAMILY PLANNING NETWORK

Through a cooperative effort with the Title X family planning agencies, federally qualified health centers, rural health clinics, the Iowa Departments of Public Health and Human Services (DHS), Iowa is providing limited Medicaid coverage for family planning-related services through the Iowa Family Planning Network (IFPN) to:

- ◆ Persons of reproductive age with countable income at or below 300% percent of the federal poverty level; and
- ◆ Any woman who had a pregnancy end on or after January 1, 2006, and who was receiving Medicaid on the date the pregnancy ended.



The DHS Family Planning Waiver (FPW) System establishes IFPN eligibility. Staff from either the family planning agencies or the DHS local office may enter applicant data for the 300% group into the Family Planning Waiver System.

IFPN eligibility for women who were receiving Medicaid at the time a pregnancy ended may be established only through entries into the Family Planning Waiver System by DHS staff or the Department's automated process.

1. Definitions

"Applicant" means a person for whom assistance is being requested, including at recertification.

"Certification period" means the time for which a person may be determined eligible for Iowa Family Planning Network.

"DHS" means the Iowa Department of Human Services.

"Grace period" means the 14 calendar days immediately following the date of denial or the effective date of cancellation.

"Primary care services" means health care provided by a medical professional and with whom a patient has initial or primary contact.

"Prudent-person concept" refers to the authority given to the clinic workers to review and analyze information given by the client and decide whether the information is sufficient for making an eligibility determination, or if further checking should be done. The "prudent person" must be vigilant, cautious, perceptive, and guided by generally sound judgment.

"Recertification" means establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Reproductive age" means at least 12 years old but under the age of 55.

"Timely notice" means a written notice given at least ten calendar days before the effective date of cancellation. The timely notice period extends from the day after a notice is issued to the effective date of action. A timely notice period must be at least ten calendar days. The Family Planning Waiver System will determine the effective date of cancellation to ensure that all cases are closed with timely notice given.



2. Processing IFPN Eligibility

Legal reference: 441 IAC 75.1(41)"a"(1), (2), (3), 441 IAC 92.2(1)

Persons eligible for services through the IFPN coverage group are:

- ◆ Persons who are 12 but not yet 55 years old and who have countable income at or below 300% of the federal poverty level.
- ◆ Women who have a pregnancy end while they are receiving Medicaid.

A person who is eligible for IowaCare, Medically Needy with a spenddown, or a Medicare Savings Program can also receive Medicaid under the IFPN program.

a. Applications

Legal reference: 441 IAC 76.1(249A); 441 IAC 75.1(41)"b"

Designated family planning agencies and clinics can assist in the processing of Medicaid eligibility for the IFPN coverage group for those persons who are at or below 300% of federal poverty level.

IFPN applicants applying at a designated family planning agency or clinic will complete form 470-2927 or 470-2927(S), *Health Services Application*. (See Chapter II for a sample of this application.)

Applications can be filed at a local DHS office, any facility where out-stationing activities are provided, with the third-party administrator for the *hawk-i* program; with presumptive Medicaid providers; at WIC offices, and at maternal or child health centers.

Applications may also be filed at the following family planning agencies and their satellite clinics:

- ◆ Allen Memorial Hospital, Waterloo
- ◆ Central Iowa Family Planning, Marshalltown
- ◆ New Opportunities, Carroll
- ◆ Edgerton Women's Health Center, Davenport
- ◆ HCCMS Family Health Services, Denison
- ◆ Hillcrest Family Services, Dubuque



- ◆ North East Iowa Community Action, Decorah
- ◆ North Iowa Community Action, Marshalltown
- ◆ Planned Parenthood of the Heartland, Burlington, Cedar Rapids, and Des Moines
- ◆ Southern Iowa Family Planning Clinic, Ottumwa
- ◆ St. Luke's Hospital, Cedar Rapids
- ◆ Unity Healthcare, Muscatine
- ◆ Visiting Nurse Services, Des Moines
- ◆ Women's Health Services, Clinton

An application is considered filed on the date form 470-2927 or 470-2927(S), *Health Services Application*, that contains a legible name, address, and signature is received by a designated family planning agency or clinic. (See [Chapter II](#) for samples of these forms.)

At the time of application, give the applicant the following information:

- ◆ Comm. 20, *Your Guide to Medicaid*. This pamphlet explains what services are available under the regular Medicaid program. Click [here](#) to see a sample of this brochure.
- ◆ Comm. 209, *Information About Your Privacy Rights*. This notice describes how medical information is used and disclosed. It also explains how clients can get access to this information. Click [here](#) to see a sample of this brochure.
- ◆ Comm. 243, *Primary Care Access*. This pamphlet explains where a person can access primary care services in Iowa. The offices listed are either rural health clinics or federally qualified health centers that generally can provide care on a sliding fee schedule. Click [here](#) to see a sample of this brochure.

b. Screening for Other Medicaid Eligibility

Screen the application to determine if eligibility may exist under other Medicaid coverage groups. Refer to *Desk Aid*, RC-0033, for income limits for other Medicaid coverage groups. Click [here](#) to see a sample of this reference card.

Explain the difference between IFPN and regular Medicaid and let the applicant choose which coverage group to apply for. One major difference is that regular Medicaid will require parents to be considered in the teen's household size and the parent's income will be counted.



If the applicant opts for IFPN, ask the applicant to sign form 470-4314, *Election of Iowa Family Planning Network*, and document the case record that the application was screened and the applicant's decision. Click [here](#) to see a sample of this form.

If the applicant wants to apply for full Medicaid benefits, send the original application to the appropriate DHS office for processing within two working days of receipt. Keep a photocopy of the application and process it for a determination of IFPN eligibility while a decision for full Medicaid coverage is being made by DHS.

c. Time Limit for Eligibility Decision

Legal reference: 441 IAC 76.3(249A)

Make entries into the Family Planning Waiver System so that the system can issue a notice of decision no later than the 30th day following the date of application. If the 30th day falls on a weekend or state holiday, process the application by making system entries no later than the next working day.

The time limit for making entries into the system can be waived in unusual circumstances such as, but not be limited to:

- ◆ When you and the applicant have made every reasonable effort to get necessary information and have not been able to do so within the time limits.
- ◆ Emergencies, such as fire or flood.
- ◆ Other conditions beyond the administrative control of the clinic.

An applicant must cooperate with the application process. This may include providing information or verification or signing documents. Failure to cooperate with the application process shall serve as a basis to deny an application.

An application cannot be denied because the 30-day period for processing it has expired. To deny the application, there must be either a failure to act on the part of the applicant or a determination of ineligibility by the Family Planning Waiver System.



d. Effective Date of Coverage

Legal reference: 441 IAC 75.1(41)"d"

The effective date of eligibility for IFPN is the first day of the month an application was filed or the first day of the month all eligibility factors are met, whichever is later.

Eligibility for IFPN cannot be granted for any month before the month of application. When an applicant requests Medicaid coverage for any of the three months before the application month, refer the application to the DHS local office for an eligibility determination.

A person found eligible for IFPN is certified for a period of 12 months, unless they will meet the age limit before 12 months or if their alien status and age requires a shortened certification period.

e. Notices of Decision

Legal reference: 42 CFR 435.919; 441 IAC 7.7(217), 7.7(1), 7.7(6), 76.4(1), and 76.4(249A)

The Family Planning Waiver System will issue a notice when:

- ◆ An application is approved, denied, or withdrawn; or
- ◆ IFPN is canceled.

Clinic staff shall print two copies of the *Notice of Decision*. Clinic staff shall provide the applicant with a copy of the *Notice of Decision* by hand delivering or mailing to the applicant at their designated mailing address. The second copy is placed in the IFPN case record.

f. Grace Period Following the Denial of an Application

Legal reference: 441 IAC 76.2(249A)

During the 14 calendar days immediately following the date of denial, the applicant has the opportunity to "cure" the reason for the denial of an application. A previously denied application shall be reconsidered when all information necessary to determine eligibility is provided within 14 calendar days of the date of denial.



“Day one” of the 14-day grace period is the day following the date printed on the notice of decision. If the 14th day falls on a weekend or a state holiday, the 14th day is extended to the next working day for which there is regular mail service.

This grace period may apply when an application has been denied for failure to provide requested information. If mail was returned and you were not able to locate the applicant, a new application is not required if the applicant contacts you within the 14 days, provides a current Iowa address, and eligibility can otherwise be established.

Any changes reported during the grace period that may affect eligibility must be verified when required by policy and be considered in the eligibility determination.

The effective date of eligibility is the first day of the month the original application was filed or the first day of the month in which all eligibility factors were met, whichever is later.

Based on the circumstances of your case, take the appropriate action as follows:

- ◆ **No information provided:** When no information is provided by the 14th day after the date of denial, no further action is required.
- ◆ **Partial information provided:** When some of the information is returned, but there is still information needed to determine eligibility:
 - Attempt to contact the applicant to let them know what is needed and that if the information is not received so that a decision can be made by the end of the grace period, they will need to reapply. A written request for the previously requested information is not required.
 - If the information is not provided by the end of the grace period, no further action is necessary.



◆ **Requested information provided and a change has occurred:**

If the original requested information is provided, but the applicant also reports a change for which verification is necessary:

- Make every effort to verify the information and inform the applicant that you cannot reconsider the application unless the change is verified by the end of the grace period. A written request for the new information is not required.
- If the new information is not verified so that an eligibility determination can be made by the end of the 14-day grace period, make entries into the Iowa Family Planning Network to indicate that the application is "still denied."

◆ **Unable to verify change within grace period:** When an additional change is reported and it is unlikely the information can be verified and eligibility established by the end of the 14-day grace period, attempt to notify the applicant to file a new application.

1. Mrs. A, an IFPN applicant, fails to provide proof of wages. The worker issues a denial dated April 2. Mrs. A provides pay stubs on April 16. There have been no other changes in circumstances. The worker reopens Mrs. A's application and re-processes it.

2. Mr. B, an IFPN applicant, fails to provide proof of wages. The worker issues a denial dated April 6. Mr. B provides the pay stubs on April 21. Since the 14-day grace period has expired, Mr. B must file a new application and the original denial stands.

3. Ms. C, an IFPN applicant, fails to provide three pieces of requested. The worker issues a denial notice dated May 11. Ms. C provides two of the items on May 13.

The worker attempts to contact Ms. C since not all of the items needed to determine eligibility came in. The third item is received on May 25. There have been no other changes in the household circumstances. The worker re-processes the application.

4. Mrs. D, an IFPN applicant, fails to provide three pieces of requested verification. The worker issues a denial notice dated May 16. Mrs. D provides two of the items on May 17.

The worker attempts to contact Mrs. D since not all of the items needed to determine eligibility came in. The third item is received on May 31. Since the 14-day grace period has expired, the worker issues a 'remain denied' notice. Mrs. D must file a new application.



5. Mr. E, an IFPN applicant, fails to provide three pieces of requested verification. The worker issues a denial notice on April 30. Mr. E provides two of the items on May 2 and the third item on May 6.

Mr. E also reports on May 6 that he changed jobs. The worker explains that in order for the original application to be reconsidered, Mr. E has until May 13 to provide verification of the new job; otherwise Mr. E will have to reapply.

Mr. E provides verification of the old job ending and the beginning of the new job on May 7. The application is processed with the new information and a notice is issued informing Mr. E of the decision.

3. Who is Not Eligible for IFPN

Legal reference: PL 104-193; 42 CFR 435.406; 441 IAC 75.1(41), 75.11(249A) and 75.10(249A)

Eligibility does not exist for IFPN if one or more of the following exists:

- ◆ The person is enrolled in the *hawk-i* program.
- ◆ The person has health insurance coverage for benefits provided under IFPN.
- ◆ The person is receiving Medicaid other than IowaCare, medically Needy with a spenddown, or the Medicare Savings Program. **NOTE:** The FPW system will identify when a person is ineligible for IFPN due to existing Medicaid eligibility.
- ◆ The person is under 12 or age 55 or older. **EXCEPTION:** The age requirement does not apply to those who are eligible for IFPN due to a pregnancy ending while receiving Medicaid.
- ◆ The person is a non-qualified alien.
- ◆ The person is a resident of another state.
- ◆ The person's countable income exceeds 300% of federal poverty level at the time of application. **EXCEPTION:** A woman who is on Medicaid when her pregnancy ends can have income above this level.



4. Household size

Legal reference: 441 IAC 75.1(41)"c"(1)

The household size includes the following people living together who **are not** receiving Supplemental Security Income (SSI):

- ◆ The applicant or member,
- ◆ The applicant or member’s spouse, and
- ◆ The applicant or member’s dependent children.

“Dependent child” means:

- ◆ A child who is under the age of 18 regardless of school attendance; or
- ◆ A child 18 years of age who is a full-time student in high school or in an equivalent program and who is expected to graduate or complete the program before reaching 19.

1. Ms. M, age 17, lives with her parents. She has no spouse and no children. Her household size is one.
2. Ms. S, age 17, has a child age 1 and lives with her parents. Her household size is two.
3. Ms. F, age 43, lives with her husband who receives SSI. Her household size is one.
4. Ms. H, age 36, lives with her husband and two children, ages 5 and 8. One child receives SSI. Her household size is three.

5. Income

Legal reference: 441 IAC 75.1(41)"c," 75.57(2)

To be eligible for IFPN, the household’s countable monthly income shall not exceed the amounts shown below for a household of the same size.

Household Size	Family Planning Income Limits (300% of Federal Poverty Level)							Add for each additional person
	1	2	3	4	5	6	7	
Income Limit	\$2,793	\$3,783	\$4,773	\$5,763	\$6,753	\$7,743	\$8,733	\$990



Clearly document the amounts used to calculate the monthly countable income. Record the applicant's income on form 470-4073, *Iowa Family Planning Network Worksheet*. (Click [here](#) to see a sample of this form.) If the applicant reports no income, document "zero," "N/A," or "\$0.00."

Keep this form along with documentation proving the household's income, such as copies of pay stubs, an employer's statement, an award letter, or the income tax return.

a. Countable Income

Legal reference: 441 IAC 75.1(41)"c"

The gross income (before taxes and other deductions) received by any person included in the household size must be counted. Income received by a parent for a teen (e.g. child support, social security benefits) is not counted for the teen's eligibility unless the parent makes it available to the teen.

NOTE: Do not count earnings of an applicant or a dependent child who is aged 19 or younger and is a full-time student in high school or in an equivalent program. A person who has completed high school and is a student in postsecondary education is not eligible for this exemption; the person's earnings must be counted.

Use and project as future income all nonexempt earned and unearned income received by a person counted in the household size determination. Any of the following may be used as a guideline:

- ◆ Income received in the 30 days before receipt of an application or review form.
- ◆ Income received in a different 30-day period that is indicative of future income.
- ◆ Income received in a longer period of time that is indicative of future income.
- ◆ One pay stub that is indicative of future income.
- ◆ Self-employment tax returns or books if indicative of future income. (This may include the past three years' average.)
- ◆ Income verification obtained from the income source.



The following income is counted in determining eligibility:

- ◆ **Money, wages or salary** received for work performed as an employee is counted as earned income. This includes commissions, tips, piece-rate payments, and cash bonuses earned. Overtime pay is estimated based on the person's history of receiving this pay.

Do not project a fifth paycheck for those who are paid weekly or a third paycheck for those who are paid biweekly.
- ◆ **Unemployment Insurance Benefits (UIB):** Count as unearned income. If UIB benefits are reduced due to recoupment, count the actual amount the person receives.
- ◆ **Child support** is counted as unearned income. This includes court-ordered or voluntary payments provided by parents for a minor child care.
- ◆ **Social Security and railroad retirement benefits** are counted as unearned income.
- ◆ **Worker's compensation and disability payments** are counted as unearned income. This type of income includes compensation received periodically from private or public insurance companies for injuries incurred at work.
- ◆ **Veterans' pensions, compensation checks, and G. I. benefits** paid by the Veterans Administration to disabled members of the armed forces or to survivors of deceased veterans are counted as unearned income.
- ◆ **Alimony:** The support payment to a divorced person by a former spouse is counted as unearned income.
- ◆ **Self-employment:** Count net profit as earned income.

b. How to Treat Self-Employment Income

Legal reference: 441 IAC 75.57(9)"h"

Medicaid self-employment income policy differentiates between (1) providing child care, (2) a home-based business, and (3) a non-home-based business.



A client who provides a service in the client's home or whose business office is in the home is involved in a home-based enterprise. The office does not need to be a separate room to meet this qualification.

Home-based self-employment operations include demonstration and sales of catalog and party-based products, painting, crafts, and cosmetology.

The treatment of self-employment income differs depending of whether the income and expenses are received regularly or irregularly, and whether irregular income has been received for less than a year.

Treat countable income (net profit) received on a regular basis from self-employment in the same way as the earnings of an employee.

Expenses must be incurred on the same regular basis as the income; that is, if the income is received monthly, the expenses must also be incurred monthly. If expenses are incurred less often than the income (for example, insurance, license fees, etc.), annualize the self-employment income.

Self-employment received on a regular basis is any income that is anticipated to be received on a daily, weekly, biweekly, semimonthly, or monthly basis. Some types of self-employment income that may be received on a regular basis are income from:

- ◆ Baby-sitting in the client's home
- ◆ Selling catalog or party-based merchandise

(1) Determination of Net Profit

"Net profit" means gross earnings minus allowable business expenses. The amount of net profit is the income that is used in determining IFPN eligibility.

- ◆ Whenever possible, use the previous year's federal income tax report to calculate monthly countable income.
- ◆ If the federal income tax report is not available, use the books or records of the business.
- ◆ If neither books nor tax records are available, do not allow any deduction for expenses related to the production of self-employment income.



Document the method used to determine income from self-employment in the case record.

Do not:

- ◆ Deduct capital gains and depreciation as business expenses;
- ◆ Offset the loss from one self-employment enterprise against the profit of another one; or
- ◆ Deduct a loss from self-employment from other income

Allowable Deduction in Determining Net Profit	HOME-BASED	NON-HOME-BASED
Cost of inventory and supplies required for business, such as items for sale or business use	X	X
Wages, commissions, and costs (including cost of health insurance) for employees. When the employee is a member of the eligible group, allow the person's wages as a deduction for the self-employed person but also count the employed person's wages as income.	X	X
Cost of machinery and equipment in the form of rent, interest on a loan for machinery and equipment, and any insurance on such machinery and equipment	X	X
Interest on a home mortgage or contract payment	X	
10% of the total gross income to cover the costs of upkeep when the work is performed in the home	X	
The cost of rent or the interest on mortgage or contract for the business location		X
Insurance on the real or personal property of the business		X
The cost of any needed repairs		X
The cost of any required travel (other than the cost of travel from the home to the business)		X
Any other expense that is directly related to producing income for the client	X	X



(2) Providing Child Care in the Home

Legal reference: 441 IAC 75.57(2)"i"

When the client provides child care services in the client's own home, determine countable income by deducting 40% of the total gross income received to cover the cost of upkeep of the home and producing the income.

Gross income from providing child care in the client's own home includes the total payment received for the service, plus any payment received under the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

However, exempt as income and as a resource any portion of the payment for the client's cost of providing meals to the client's own children in the home.

When the client claims to have expenses in excess of the 40% and asks to have actual expenses considered, determine allowable deductions according to the [chart](#) under [Determination of Net Profit](#).

NOTE: Use actual expenses only at the client's request and only when they exceed 40% of the gross income. This may require a computation of net income using both methods to determine which is to the client's advantage. When you use the 40% deduction, do not allow 10% deduction for upkeep.

Income received from the Child Nutrition Amendments of 1978 must be reported and verified. Tell the client about this responsibility.

NOTE: The amount you record as gross income on the IFPN Worksheet is the gross amount minus the 40%.



Ms. S earns \$400.00 weekly from providing child care in her home resulting in a monthly gross income of \$1,600.00. Manually calculate the 40% deduction. This deduction is \$640.00.

Monthly gross income	\$ 1,600.00
40% deduction	- 640.00
Countable gross income	\$ 960.00

On the IFPN Worksheet or in the FPW system, in the Earned Income section, under Total, enter \$960.00.

(3) Annualizing Income Received Irregularly

Legal reference: 45 CFR 233.20(a)(3)(iii), 441 IAC 75.57(9)“i”

When self-employment income is received on an irregular basis, average the annual income over a 12-month period, even if the income is received only within a short period in that 12 months.

Apply this policy when the income is received before or in the month of decision and expected to continue. (Do **not** consider any self-employment income received before the month of application if it is not expected to continue.)

If a client is self-employed in a business that does not produce a regular income, and the business has been in existence for less than a year, average the income over the period the business has been in existence to arrive at monthly income.

If the business has been in existence for only a short time and there is little income information, establish a reasonable estimate of income and expenses with the client’s help.

After you have determined the net profit, enter the figure into the Family Planning Waiver System.



c. Deductions From Gross Income

Legal reference: 441 IAC 75.1(41)"a"(2)3

Reduce gross income by the following amounts before comparing income to the limit for a household of the same size. Proof of payments for court-ordered child support, alimony, or spousal support shall be documented in the case record. A court pay record may document court ordered deductions.

- ◆ 20% of gross earned income.
- ◆ Child or incapacitated adult care expense for work-related hours that is not paid by a third-party source such as the Child Care and Development Block Grant, or the Child Care Assistance Program.
 - Up to \$200 per month per child under age two
 - Up to \$175 per month per adult or child age two or older
- ◆ Payments made for court-ordered child support, alimony, or spousal support.

1. Ms. S, age 17, applies for IFPN. She lives with her parents who are both employed. Ms. S attends high school and works part-time at a local convenience store making \$125 weekly.

The income of her parents is not counted. The earnings Ms. S makes from her part-time job is not counted, as she is a full-time high school student.

2. Ms. M, age 15, applies for IFPN. She lives with her mother, who is employed. Ms. M's father is deceased. Her mother receives Social Security benefits of \$600 per month for Ms. M.

The Social Security benefit is not counted, since Ms. M does not have access to this income. The mother's earnings are not counted. Ms. M has no income to count. Ms. M is eligible for IFPN.

3. Ms. N, age 35, lives with her husband and two children. Her husband gets \$300 weekly unemployment insurance benefits. The children receive Medicaid under the Mothers and Children coverage group. Ms. N is eligible for IFPN since the family income of \$1,200 is less than 300% of the federal poverty level for a household of four.



4. The household consists of Ms. R, age 25, and her daughter, age 3. Ms. R is employed with monthly gross earned income of \$1,800. Due to employment, Ms. R has a weekly child care cost of \$75.

Monthly gross income	\$ 1,800.00
Minus 20%	- 360.00
	\$ 1,440.00
Minus child care expense	- 175.00
Countable income	\$ 1,265.00

Ms. R is eligible for IFPN since her countable income is less than the 300% of the federal poverty level for a household of two.

5. Ms. D, age 42, lives with her husband and son, who dropped out of high school and who is age 17. Ms. D is unemployed, her husband receives unemployment insurance benefits of \$320 per week, and her son earns \$100 per week from working part time.

Monthly gross earned income	\$ 400.00
Minus 20%	- 80.00
	\$ 320.00
Plus unemployment benefits	+ 1,280.00
Countable income	\$ 1,600.00

Ms. D is eligible for IFPN since the countable income is less than the 300% of the federal poverty level for a household of three.

6. Nonfinancial Eligibility Requirements

a. Medicaid or *hawk-i* Eligibility

A teen enrolled in *hawk-i* is not eligible for IFPN. Call *hawk-i* Customer Service at 1-800-257-8563 to verify *hawk-i* enrollment. If a teen becomes enrolled after IFPN is approved, you will be notified by the IFPN Help Desk to close the teen's IFPN case.

A person cannot be eligible for the IFPN if the person is currently receiving Medicaid. Clinic staff can verify Medicaid eligibility by either:

- ◆ Calling the Eligibility Verification System (ELVS) at 1-800-338-7752 or 515-323-9639; or
- ◆ Verifying eligibility on the Internet at <http://www.ime.state.ia.us/Providers/OnlineTools.html>



EXCEPTION: A person eligible for IowaCare, Medically Needy with a spenddown, or a Medicare Savings Program can also be eligible for IFPN.

The FPW system will identify when a person is ineligible for IFPN due to existing Medicaid eligibility and will deny the application.

b. Age

Legal reference: 441 IAC 75.1(41)"a"(2)

To be eligible for IFPN, person must be of reproductive age.

c. Social Security Number

Legal reference: 441 IAC 75.7(249A) and 9.3(3)

A social security number is required for each person for whom IFPN is being requested or received. This requirement does **not** apply to a person who is a member of a recognized religious sect who conscientiously opposes applying for or using a social security number.

d. Health Insurance

A person that is uninsured or has health insurance that does not include family planning services may be eligible for IFPN, if other eligibility criteria are met.

A person who is covered under group or private health insurance is eligible for IFPN if the person can claim good cause for not cooperating in filing a claim for health insurance. A person can claim good cause due to confidentiality if the person is fearful of the consequences.

e. Confidentiality Good Cause

A person can claim good cause for not cooperating in filing a claim for health insurance if the person is fearful of the consequences.

1. Mr. M, age 17, lives with his parents. He does not want his parents to know he is seeking family planning services. He can claim good cause for not claiming health insurance benefits.
2. Ms. J is married and her husband has health insurance. Her husband does not want her receiving family planning services. Ms. J can claim good cause.



f. Residency

Legal reference: 441 IAC 75.53(1) and 75.53(2)

A person must be a resident of Iowa to be eligible for IFPN. A child is considered a resident of the state in which the parent or other person responsible for the child's care, custody, and control resides.

Consider a person a resident of Iowa if the person meets one of the following criteria:

- ◆ The person is living in Iowa voluntarily, intends to make a home in the state, and is not in Iowa for a temporary purpose.
- ◆ The person does not receive assistance from another state and entered Iowa with a job commitment or to seek employment, whether or not the person is currently employed. In this case, the child is a resident of the state in which the caretaker is a resident.

Do not consider a person a resident of Iowa if the person is:

- ◆ In Iowa solely on vacation (such as a child who lives with a parent in another state but spends the summer with the other parent in Iowa).
- ◆ Living in Iowa on a temporary basis (such as a child who lives in Iowa to attend school but whose parents continue to maintain a home for the child in another state and claim the child as a dependent for income tax purposes, including foreign students).

Residency continues until the client has left the state. When a person temporarily leaves the state but plans to return, do not cancel assistance based on residency requirements.

Continued maintenance of a home in Iowa or the fact that most household goods remain in the state is considered evidence of temporary absence from Iowa. However, the acceptance of employment or the enrollment of the child in school in the other state is an indication that Iowa residency may have been abandoned.



g. Citizenship

Legal reference: P. L. 99-603, P. L. 104-193; P. L. 111-3, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); 42 CFR 435.406; 441 IAC 75.11(249A)

To be eligible for IFPN, a person must be one of the following:

- ◆ A U.S. **citizen**, defined as:
 - A person born in the United States,
 - A person born of parents who are citizens living outside the United States, or
 - A person granted citizenship status.

For purposes of qualifying as a U.S. citizen, "United States" is defined as the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and the North Mariana Islands.

- ◆ A **national** of the United States, defined as a person born in American Samoa or the Swain Islands. The Independent State of Samoa (also known as Western Samoa) is not part of American Samoa, so individuals from this county are not U.S. nationals.
- ◆ A **qualified alien**. See [Alien Status](#) for more information on services and eligibility criteria.

"**Lawfully residing**" aliens may be either immigrants or nonimmigrants that the Department of Homeland Security considers long-term residents who have moved to the United States, are not required to maintain permanent residence in another country, and are allowed to remain in the United States either permanently or indefinitely.

NOTE: Persons from the Compact of Free Association States (CFAS) are not U.S. citizens or nationals. The CFAS includes the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau.

Persons from the CFAS retain citizenship in their country of origin but are allowed to enter and work in the United States without obtaining an immigration status. Adult CFAS citizens (ages 21 and over) **are not** eligible for IFPN. However, children under age 21 who are CFAS citizens and are lawfully residing in the United States may be eligible for IFPN.



Applicants must declare their citizenship or alien status as part of the application process by signing a state-approved Medicaid application. Applicants must also provide original documentation to verify their citizenship or alien status.

People who are not citizens or nationals by birth can become citizens through a process called "naturalization." In addition, certain children born abroad who were not U.S. citizens at the time of birth may establish citizenship automatically under the Children Citizenship Act. See [Acceptable Documentation](#) for more information about verification of automatic citizenship.

See [Citizenship and Identity Documentation Chart](#) for acceptable forms of citizenship and identity verification. See [Alien Documentation Chart](#) for information about acceptable forms of verification for alien status.

(1) Acceptable Documentation

Legal reference: 42 CFR 435.407; 441 IAC 75.11(2)"c," "d," and "e"; P. L. 111-3

Original documents or copies certified by the issuing agency are required. "Certified" means that the document is stamped, embossed, or otherwise noted in writing by the agency responsible for maintaining the original that it is a true copy of the original. Copies or notarized copies of documents are not acceptable proof.

NOTE: Copies of original documents are acceptable only when made by the Department's employees (including staff outstationed at other locations), *hawk-i* staff, or by staff authorized under contract, such as IFPN providers and staff at University of Iowa Hospitals and Clinics who are authorized to take initial applications.

Documents submitted by a person whose last name has changed (e.g. due to marriage or divorce) may be accepted if the documents match in every way except the last name. If there is reason to question whether the documents belong to the same person, request an official document verifying the change (e.g. marriage license or the divorce decree).



Citizenship documents are arranged in a hierarchy from most reliable (Level 1) to least reliable (Level 4). Level 1 documents are acceptable proof of both citizenship and identity. If Level 2, Level 3, or Level 4 documents are used to verify citizenship, separate proof of identity is also required.

Obtain the most reliable record the person has available. Accept less reliable documents only when more reliable documents do not exist or cannot be obtained within the reasonable opportunity period.

When a lower-level document is available, you may accept it if a higher-level document cannot be obtained within the normal time limits for processing an application or automatic redetermination. In this situation, the higher-level document is not considered available.

EXCEPTION: Do not accept a lower-level document when a Birth Certificate Verification (BCV) system match can be done, even if waiting for the BCV match requires exceeding normal processing time limits.

There is no hierarchy of documents for identity. However, accept the three or more corroborating documents or an affidavit only as a last resort.

This chart lists documents acceptable as verification of citizenship and identity:

(2) Citizenship and Identity Documentation Chart

Level 1: Primary Documents	Verifies both citizenship and identity
Confirmation of citizenship via SVES automated data match	US citizenship and identity has been verified by the Social Security Administration based on a data match through Security Validation Enumerations System (SVES). This match can be attempted only for a person who provides a name, date of birth, and social security number.



Level 1: Primary Documents (Cont.)	Verifies both citizenship and identity
U.S. passport	<p>The Department of State issues U.S. passports. An expired passport may be accepted as evidence of U.S. citizenship and identity as long as it was originally issued without limitation.</p> <p>Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</p> <p>NOTE: Spouses and children were sometimes included on one passport through 1980. The citizenship and identity of all of the persons included can be established when one of these passports is presented. U.S. passports issued after 1980 show only one person.</p>
<i>Certificate of Naturalization</i> (Department of Homeland Security Form N-550 or N-570)	Issued when a person becomes a naturalized citizen.
<i>Certificate of U.S. Citizenship</i> (Department of Homeland Security Form N-560 or N-561)	Issued to persons whose U.S. citizenship is derived through a parent.
Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe. (Examples include Tribal enrollment or membership cards, a certificate of degree of Indian blood issued by the Bureau of Indian Affairs, or a Tribal census document.)	<p>Until federal regulations are issued on satisfactory documentation for Tribes having an international border whose membership includes non-U.S. citizens, members of cross-border Tribes may use Tribal enrollment or membership documents for purposes of proving both citizenship and identity.</p> <p>The list of federally recognized Indian Tribes is maintained at http://www.usdoj.gov/otj/resources.htm</p>



Level 2: Secondary Documents	Verifies citizenship only
<p>U.S. public birth certificate showing birth in:</p> <ul style="list-style-type: none">◆ One of the 50 states or the District of Columbia◆ American Samoa◆ Swain's Islands◆ Puerto Rico on or after January 13, 1941◆ The U.S. Virgin Islands on or after January 17, 1917◆ The Northern Mariana Islands after November 4, 1986◆ Guam on or after April 10, 1899	<p>The state, commonwealth, territory, or local jurisdiction may issue the birth record document.</p> <p>This includes a successful match with Iowa birth records through the Birth Certificate Verification (BCV) system. See 14-C(2) for information on how to complete the BCV match.</p> <p>The birth record must have been recorded before the person was 5 years old. Birth certificates recorded after age 5 can be used only as Level 4 documentation.</p> <p>If the document shows that a person was born in Puerto Rico, Guam, the Virgin Islands, or the Northern Mariana Islands before the dates listed, contact SPIRS help desk for assistance in determining whether the person is a collectively naturalized U.S. citizen.</p>
<p><i>Certification of Report of Birth</i> (Form DS-1350)</p>	<p>This form is issued by the Department of State to U.S. citizens who were born outside the United States and acquired U.S. citizenship at birth.</p>
<p><i>Consular Report of Birth Abroad of a U.S. Citizen</i> (Form FS-240)</p>	<p>This form is issued by the Department of State via American consular offices overseas to children under the age of 18. Children born to U.S. military personnel usually have such a form.</p>
<p><i>Certification of Birth Abroad</i> (Form FS-545)</p>	<p>Before November 1, 1990, Department of State consulates also issued this form with the previous version of form FS-240.</p>



Level 2: Secondary Documents (Cont.)	Verifies citizenship only
<i>U.S. Citizen I.D. Card</i> (Department of Homeland Security Form I-197 or the earlier version Form I-179)	<p>Form I-179 was issued from 1960 to 1973. Then it was renumbered to form I-197 and was issued until April 7, 1983.</p> <p>These forms were issued to naturalized citizens living near the Canadian or Mexican border who needed identification for frequent border crossings. Although not currently issued, they are still valid.</p>
<i>American Indian Card</i> (I-872) with "KIC" classification	<p>Form I-872 is issued by the Department of Homeland Security to identify U.S. citizen members of the Texas band of Kickapoos living near the U.S./Mexico border. The "KIC" classification code and a statement on the back denote U.S. citizenship.</p>
<i>Northern Mariana Identification Card</i> (I-873)	<p>Form I-873 was issued by the former Immigration and Naturalization Service to a collectively naturalized U.S. citizen who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but is still valid.</p>
Final adoption decree	<p>The decree must show the child's name and U.S. place of birth.</p> <p>When an adoption is not finalized and the state in which the child was born will not release a birth certificate before final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The agency must state in its certification that the source of the information is an original birth certificate.</p>



Level 2: Secondary Documents (Cont.)	Verifies citizenship only
Verification of automatic citizenship under section 320 of the Immigration and Nationality Act, also known as Child Citizenship Act	<p>Children born outside the United States who were not U.S. citizens at the time of birth (international adoptions and certain children born abroad whose parents become naturalized citizens) may establish citizenship automatically by providing verification that at any time on or after February 27, 2001, the child met the following conditions:</p> <ul style="list-style-type: none">◆ The child is under age 18.◆ At least one parent is a U.S. citizen by birth or naturalization.◆ The child is residing in the United States in the legal and physical custody of the U.S. citizen parent pursuant to a lawful admission for permanent residence. <p>If adopted, the child was admitted as either having an immigration status of IR-3 (adopted outside the United States) or IR-4 (final adoption within the United States).</p> <p>The parent's status must be verified according to citizenship guidelines. The child's status for admission to the United States must be verified according to alien guidelines. The adoption must be verified by obtaining a copy of the full, final adoption decree.</p>
Official military record of service	The document must show a U.S. place of birth (for example a DD-214).
Evidence of employment by the U.S. government civil service	The document must show employment by the U.S. government before June 1, 1976.



Level 3: Other Documents	Verifies citizenship only
Extract of hospital record on hospital letterhead that shows a U.S. place of birth	<p>For persons aged 16 or over, the record must have been established at the time of the person’s birth and the document created at least 5 years before the Medicaid application date.</p> <p>For children under age 16, the document must have been created near the time of birth or 5 years before the Medicaid application date.</p> <p>NOTE: A souvenir “birth certificate” issued by the hospital does not qualify.</p>
Life, health, or other insurance record showing a U.S. place of birth	<p>For persons aged 16 or over, the record must have been created at least 5 years before the Medicaid application date.</p> <p>For children under age 16, the document must have been created near the time of birth or 5 years before the Medicaid application date.</p>
Religious record showing either the date of birth or the person’s age when the record was made	<p>The document must be an official record that was recorded with the religious organization in the United States within three months of birth.</p> <p>Caution: In questionable cases (e.g., a record recorded near a U.S. international border and the child may have been born outside the United States), the state must verify the record or document that the mother was in the United States at the time of birth.</p>
Early school record showing a U.S. place of birth	The record must show the child’s name, date of admission to the school, date of birth, U.S. place of birth, and the names and places of the person’s parents.

NOTE: With the exception of written affidavits, all Level 4 documents must show a U.S. place of birth and must have been created at least five years before the application for Medicaid (or near the time of birth, for children under 16).



Level 4: Other Documents	Verifies citizenship only
<p>Other documents listed that show a U.S. place of birth and were created at least five years before the Medicaid application date</p>	<ul style="list-style-type: none">◆ Seneca Indian tribal census record◆ Bureau of Indian Affairs tribal census records of the Navaho Indians◆ Roll of Alaska Natives maintained by the Bureau of Indian Affairs for persons born before December 18, 1971. (Contact SPIRS for assistance requesting information from the Roll.)◆ Any U.S. state's vital statistics official notification of birth registration◆ A delayed U.S. public birth record that is recorded more than five years after the person's birth <p>NOTE: A birth certificate recorded five years or less after the person's birth qualifies as a Level 2 document.</p> <ul style="list-style-type: none">◆ Statement signed by the physician or midwife who was in attendance at the time of birth
<p>Medical (clinic, doctor, or hospital) record</p>	<p>Medical records generally show biographical information for the person, including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth.</p> <p>Note: An immunization record maintained by a parent or school is not considered a medical record but an immunization record maintained by a clinic, doctor, or hospital is considered a medical record for this purpose.</p>



Level 4: Other Documents	Verifies citizenship only
<p>Affidavit signed under penalty of perjury:</p> <p><i>Affidavit Concerning Documentation of Citizenship, form 470-4374</i></p> <p><i>Affidavit of Citizenship, form 470-4373</i></p>	<p>Form 470-4374 must be completed by the client or by another knowledgeable person (guardian or representative) explaining why the person does not have and cannot get any of the other documents to prove citizenship.</p> <p>Two people with personal knowledge of the events establishing the client's claim of citizenship must complete form 470-4373. Only one of these can be related to the person. They must also verify their own citizenship and identity.</p> <p>NOTE: If an affidavit is used to prove citizenship, an affidavit cannot be used to prove identity.</p> <p>An affidavit is the only Level 4 document that does not have to show a U.S. place of birth or have been created five years before the Medicaid application. It may be used for both U.S. born and naturalized citizens. It may be used only as a last resort when no other documents are available.</p>

NOTE: Documents used to prove identity should be current. Identity documents that have recently expired may be accepted as long as there is no reason to question that they match the individual. Use the "prudent person" concept in deciding whether a document is "current" or "recently expired."

Identity Documents:	Explanation:
<p>Driver's license issued by a U.S. state or territory</p>	<p>Acceptable if the license has a photograph of the person or identifying information such as name, age, sex, race, height, weight, or eye color.</p>



Identity Documents:	Explanation:
ID card issued by a state, federal, or local government	Acceptable if the ID has the same information included on driver's licenses e.g. a photograph or other identifying information such as name, age, sex, race, height, weight, or eye color. NOTE: A voter's registration card or Canadian driver's license may not be accepted.
U.S. military card or draft record	Self-explanatory.
Cross match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system; if the agency establishes and certifies the true identity of the individuals	This includes data matches with Iowa Department of Transportation (DOT) driver's license information. Remember to print the driver's license information screen and file it in the case file as proof.
Military dependent's identification card	Acceptable if it contains the person's photograph.
School ID card with a photograph	Self-explanatory.
U.S. Coast Guard Merchant Mariner card	Self-explanatory.
U.S. passport issued with limitations	Contact the IFPN help desk for any questions about the document.
For children under age 16: Clinic, doctor, hospital, or school record	School records include day care records and report cards. School records must be verified with the issuing school.



Identity Documents:	Explanation:
<p>If none of the evidence of identity listed above is available, three or more corroborating documents may be accepted if the same items were not used to document citizenship.</p> <p>This option can be used only if the person submitted 2nd-level or 3rd-level citizenship documentation.</p>	<p>Documents that together reasonably corroborate a person’s identity may be used, such as employer identification cards, high school or college diplomas, marriage certificates, divorce decrees, and property deeds or titles.</p> <p>All documents must contain the person’s name and must contain consistent identifying information.</p>

(3) Verifying Citizenship and Identity

Legal reference: 42 CFR 435.406 and 435.407; 441 IAC 75.11(2)"f"; Sections 211(a) and 211(b)(3) of Public Law 111-3

Unless specifically exempted, all Medicaid applicants or members claiming to be United States citizens are required to certify their citizenship and identify as a condition of eligibility. In most cases, Medicaid is available while the client is verifying citizenship and identity. See [Reasonable Opportunity Period](#).

Procedure:

When acceptable proof of citizenship and identity is provided, document that both citizenship and identity have been verified by entering coding in the FPW system.

Unless the person’s citizenship is verified through the automated SVES match, record the type of verification obtained from each person in the FPW system.

Make entries on the Non-Financial Information screen in the fields HOW WAS CITIZENSHIP VERIFIED and HOW WAS IDENTITY VERIFIED. Acceptable codes for each field are displayed in a drop down box.



You must maintain a file that contains copies of the documents used to verify citizenship and identity for each person approved for IFPN.

Keep this documentation in the active case file unless citizenship was verified through the automated Social Security Validation Enumeration System (SVES). When citizenship is verified through the SVES match, a record of the proof will be maintained electronically and displayed on the Search Result screen.

NOTE: A person is required to provide proof of citizenship and identity only once. Once provided, proof cannot be required again as a condition of Medicaid eligibility unless there is a reason to question the proof that was previously provided.

(4) Documentation Process for SVES Match

Legal reference: 42 CFR 435.407; 441 IAC 75.11(2)"c"

Policy:

A person who attests to U.S. citizenship and provides name, social security number, and date of birth meets the citizenship and identity documentation requirements if the respond to submission of this information to the Social Security Administration verifies the person's citizenship and identity.

A written request for verification shall be issued if:

- ◆ The Social Security Administration returns a response that does not verify the person's citizenship and identity.
- ◆ A response cannot be requested from the Social Security Administration because the person does not have a social security number.
- ◆ The person has previously had a 90-day reasonable opportunity period to verify citizenship for Medicaid (including IFPN) or *hawk-i*.



Procedure:

When processing an application, the FPW system will automatically send a request for proof of citizenship and identity to the Social Security Administration via SVES if you answer "yes" to the question "Do you want to request a SVES match?"

Do not request a SVES match when the Search Result screen already has a code in the US or ID fields indicating that citizenship or identity was already verified. **Do not** edit or override the HOW CITIZENSHIP WAS VERIFIED or HOW WAS IDENTITY VERIFIED fields in the Case information/Non-Financial screen when they indicate that citizenship and identity was already verified.

An SVES request for proof of citizenship and identity will **not** be sent when coding in **both** the US and ID fields indicates that verification is not needed (e.g., verification is already on file, person is an alien). When an SVES request will not be generated for a person who is required to verify citizenship and has not done so, follow the procedure under [No Match](#).

Request a SVES match **only** when processing a person who:

- ◆ Attests to U.S. citizenship,
- ◆ Has not yet had the 90-day reasonable opportunity period, and
- ◆ Is required to verified citizenship and identity but has not already done so, as indicated by coding in the Search Results screen.

When you request a SVES match for an IFPN applicant or member:

- ◆ The system will update the fields US and ID to show a "?" in the Search Result screen.
- ◆ You **must** set a reminder to go back and check the status of the SVES request in **48 hours**.

You may obtain proof of citizenship and identity directly from the applicant so that documentation is already on file in case the Social Security Administration is unable to verify the person's citizenship.



(5) Consistent Match

Policy:

When the response to a SVES request for proof of citizenship and identity is a "consistent match" this verifies the person's citizenship and identity. The person has met the citizenship and identity documentation requirements.

Procedure:

When the SVES response reports a consistent match, the system will:

- ◆ Show the response in the Search Result screen, and
- ◆ Automatically update the coding in the US and ID fields on the person's "Search Screen" to a "+."

No further action is needed for that person's ongoing IFPN case.

(6) Inconsistent Match

Policy:

When the SVES response is an "inconsistent match," the person's citizenship and identity are not verified. The FPW system will generate a written request for verification of citizenship and identity to notify the person that:

- ◆ The person has 90 days to provide verification by either:
 - Correcting any errors in the name, social security number, or date of birth given to the family planning agency so that Social Security Administration (SSA) can verify the person's citizenship; or
 - Correcting any errors in the SSA's records and providing proof of citizenship and identity from SSA when this is done; or
 - Providing proof of citizenship and identity from the list of document described under [Acceptable Documentation](#).
- ◆ If verification is not provided within 90 days:
 - IFPN eligibility will end,
 - IFPN will not be approved again in the future until citizenship and identity are verified.



Procedure:

When the response is received that SSA cannot verify the person's citizenship and identity, the system will automatically:

- ◆ Show the response in the Search Result screen.
- ◆ Change the code in the US and ID fields on the person's Search Result screen from "?" to "-" unless there is already a valid code in that field.
- ◆ Calculate and display the 90-day due date in the Search Result screen under field 90-DAY DATE.
- ◆ Generate form 470-4858, *Request for Verification of Citizenship and Identity*, and Comm. 258, *Verifying Citizenship and Identity*.

Set up a reminder for the date that the 90-day reasonable opportunity period is due. Manually cancel the IFPN case at the end of the reasonable opportunity period if proof for citizenship and identity is not provided by the due date.

If acceptable proof is provided, record the receipt of documentation in the Search Result Edit screen under fields HOW WAS CITIZENSHIP VERIFIED and HOW WAS IDENTITY VERIFIED.

If the person has corrected errors in the SSA's records:

- ◆ Make the appropriate corrections in the Search Edit screen **and**
- ◆ Resend the request by answering "yes" to question "Do you want to request a SVES match?"
- ◆ Otherwise, enter the code indicating the corresponding document from the list provided under the drop down box.

If proof is provided but is questionable or not acceptable:

- ◆ Contact the person by phone or mail.
- ◆ Explain why the proof submitted is not acceptable and how acceptable proof can be obtained (see back of Comm. 258).
- ◆ Document phone contacts in the case file.

Cancel the person's IFPN at the end of the 90-day reasonable opportunity period due to lack of proof of citizenship and identity, the system will allow timely notice.



(7) No Match

Policy:

An SVES request for proof of citizenship and identity will not be sent when:

- ◆ A "?" is coded in the US or ID fields for a person who does not have social security number.
- ◆ A request was already sent and the person's name, date of birth, social security number or sex has not been changed in the Search Result Edit screen.

A written request for verification shall be issued. IFPN shall be approved during the 90-day reasonable opportunity period.

Procedure:

When proof of citizenship is required for a person but cannot be requested via SVES, a written request for proof will be system-generated. The request notifies the person that if proof of citizenship and identify is not provided within 90 days:

- ◆ IFPN eligibility will end.
- ◆ IFPN will not be approved again in the future until citizenship and identity is verified.

Form 470-4858, *Request for Verification of Citizenship and Identity*, and Comm. 258, *Verifying Citizenship and Identity*, will be system-generated and sent to a person who:

- ◆ Is approved on the system,
- ◆ Has an invalid SSN, and
- ◆ Has a "?" code in the US or ID fields.

If a person later provides a valid social security number, entry of the social security number will cause a request for proof of citizenship to send via SVES. However, because only one 90-day reasonable opportunity period is allowed for each individual form 470-4858, *Request for Verification of Citizenship and Identity*, will **NOT** be generated again.

Cancel the person's IFPN case at the end of the 90-day reasonable opportunity period due to lack of proof of citizenship and identity, the system will allow timely notice.



(8) Reasonable Opportunity Period

Legal reference: 42 CFR 435.407; 441 IAC 75.11(2)"c"

Policy:

A person shall be allowed a reasonable opportunity period to obtain and provide proof of citizenship and identity. The reasonable opportunity period begins with the date a written request to provide the information is issued to the person and continues for 90 days.

Medicaid (IFPN) shall be approved during the 90-day reasonable opportunity period for applicants and shall continue for members who have not previously been required to provide proof of citizenship and identity.

Medicaid (IFPN) shall not be approved for an applicant or continued for a member who has already received a reasonable opportunity period until proof of citizenship and identity is provided.

Procedure:

Whenever possible, obtain proof of citizenship and identity through an automated SVES match with the Social Security Administration.

If you request a SVES match for an IFPN applicant or member, you **must** set a reminder to go back and check the status of the SVES request in **48 hours**. If the match is **consistent**, the system will update citizenship and identity coding.

If the SVES match is **inconsistent** or **unavailable**, the system will generate form 470-4858, *Request for Verification of Citizenship and Identity*, and Comm. 258, *Verifying Citizenship and Identity*. The system will sent these forms to the client at the address recorded in the FPW system.

If the SVES match is **inconsistent**, the **system** will:

- ◆ Calculate the reasonable opportunity period and make it available for view at the Search Result screen in the FPW system under the field called 90-DATE DATE.
- ◆ The Search Result screen will display the following information:
 - SVES response
 - Issuance of form 470-4858 (yes or no)
 - 90-day due date



If the SVES match is **inconsistent**, the **worker** must:

- ◆ Set up a reminder and track the date that the reasonable opportunity period is due.
- ◆ Cancel the IFPN case at the end of the reasonable opportunity period, using the "Quick Cancel" function, if proof for citizenship and identity is not provided by the due date.

If acceptable proof is provided, record the receipt of documentation in the Search Result Edit screen under fields HOW WAS CITIZENSHIP VERIFIED and HOW WAS IDENTITY VERIFIED.

To keep the system from incorrectly blocking subsequent IFPN approvals, record receipt of the proof in the Search Result Edit screen even if the person is not currently in an active IFPN status.

NOTE: Form 470-4858, *Request for Verification of Citizenship and Identity*, is not available for worker issuance because this would interfere with the system calculating the one 90-day reasonable opportunity period allowed for each person.

You may request a copy of this form to the IFPN Help Desk, if necessary (e.g., if the client loses the original).

h. Alien Status

Legal reference: Section 121 of the Immigration and Control Act of 1986 (P. L. 99-603); P. L. 104-193; 441 IAC 75.11(1)

Legal aliens may be eligible or ineligible for IFPN, depending on their immigration status.

Aliens described under [Aliens Exempt from Five-Year Bar](#) may be eligible for IFPN from the date they obtained alien status; regardless of the date they enter the United States.

Aliens described under [Aliens Subject to Five-Year Bar](#) are not eligible for five years after their date of entry. The five-year period of ineligibility begins on the date of the person's entry into the United States with one of the listed statuses.



(1) Aliens Subject to Five-Year Bar

Legal reference: 441 IAC 75.11(249A), Public Law 104-193

Aliens listed in this section who enter the United States on or after August 22, 1996, are barred from receiving IFPN and Medicaid (except emergency services) for five years. The five-year period begins on the date the person enters the United States with one of the following statuses:

- ◆ Aliens aged 21 or over who are lawfully admitted for permanent residency (LPR).

NOTE: Lawfully permanent residents may be required to have a sponsor and may be subject to deeming of income or resources from the sponsor. See 4-L, [Sponsor Affidavits of Support and Deeming](#), for more information.

- ◆ Aliens aged 21 or over who are paroled into the United States under section 212(d)(5) of the Immigration and Nationality Act (INA) for a period of at least one year.
- ◆ Aliens aged 21 or over who are granted conditional entry under section 203(a)(7) of the INA as in effect before April 1, 1980.
- ◆ Battered aliens ages 21 or over under 8 USC 1641(c).

NOTE: The five-year bar does not apply to aliens in these categories who entered the United States before August 22, 1996, or to children who are under the age of 21.

(2) Aliens Exempt from Five-Year Bar

Legal reference: 441 IAC 75.11(249A), P. L. 104-193

Aliens with one of the following statuses are eligible for IFPN from the date they obtain the status:

- ◆ Refugees admitted under section 207 of the Immigration and Nationality Act (INA).
- ◆ Aliens granted asylum under section 208 of the INA.
- ◆ Aliens whose deportation or removal is withheld under section 243(h) or section 241(b)(3) of the INA.
- ◆ Cuban or Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980.



- ◆ Amerasian immigrants.
- ◆ Canadian born American Indians who have treaty rights to cross the United States borders with Canada and Mexico. There is an extensive list of these tribes. Contact the IFPN Help Desk if you question whether a tribe is included.
- ◆ Aliens lawfully admitted for permanent residence who are veterans honorably discharged for reasons other than alienage and their spouses, surviving unremarried spouses, and unmarried dependent children. This includes alien spouses, surviving unremarried spouses, and unmarried dependent children of veterans who are U.S. citizens or deceased veterans.
- ◆ Aliens lawfully admitted for permanent residence who are active-duty personnel of the United States Armed Forces and their spouses, surviving unremarried spouses, and unmarried dependent children of active duty personnel who are U.S. citizens or deceased active-duty personnel.

“Active duty” excludes temporary full-time duty for training purposes performed by members of the National Guard or Reserves.

- ◆ Aliens who entered the United States before August 22, 1996.
- ◆ Victims of trafficking with an Office of Refugee Resettlement (ORR) certification letter that has been verified by calling the trafficking verification line. **Contact the IFPN help desk for assistance.**

Trafficking victims are eligible only for eight months from the entry date in the original ORR certification letter unless ORR issues a recertification letter.

Without the ORR certification or when the ORR certification expires, trafficking victims are not eligible for Medicaid unless another qualifying status is obtained.

- ◆ Iraqi and Afghan special immigrants. See 8-L, [Iraqi and Afghan Special Immigrants](#), for specific instructions. These special immigrants are lawful permanent residents but are eligible for Medicaid to the same extent as refugees.



- ◆ Alien children under the age of 21 who are:
 - Aliens paroled into the United States under section 212(d)(5) of the INA for a period of at least one year;
 - Battered aliens under 8 USC 1641(c). Refer to 8-L, [Battered Aliens](#), for more information; or
 - Aliens in one of the statuses listed following the definition of “lawfully residing” in 8-L, [Alien Categories](#). Only children under age 21 in a lawfully residing status are qualified aliens and may be eligible for IFPN, if all other eligibility requirements (including [residency](#)) are met.

NOTE: Verification that these children continue in one of these statuses is required at each annual review.

- Attempt to use the documentation presented at application to verify then child’s continued lawfully residing status.
- If additional documentation is needed, the household must provide proof of continued lawfully residing status for the child.

When these lawfully residing children reach age 21, they become ineligible for IFPN unless they obtain another qualified alien status.

(3) Establishing Qualifying Quarters

When a lawful permanent resident is not otherwise exempt from sponsor deeming, you must determine the number of qualifying quarters with which the person can be credited. A lawful permanent resident becomes exempt from sponsor deeming when credited with 40 qualifying quarters.

Each person can get up to a total of four qualifying quarters of credit each calendar year based on the person’s own earnings. The person may be credited with additional quarters in a calendar year based on earnings of a parent or spouse as described in this section.

The following chart lists the amount a person had to earn to get one credit for the years 1978 and later. (For years before 1978, contact the IFPN help desk for assistance.)



Amount Needed to Earn a Qualifying Quarter			
Year	Earnings Needed to Get One Credit	Year	Earnings Needed to Get One Credit
1978	\$250	1995	\$630
1979	\$260	1996	\$640
1980	\$290	1997	\$670
1981	\$310	1998	\$700
1982	\$340	1999	\$740
1983	\$370	2000	\$780
1984	\$390	2001	\$830
1985	\$410	2002	\$870
1986	\$440	2003	\$890
1987	\$460	2004	\$900
1988	\$470	2005	\$920
1989	\$500	2006	\$970
1990	\$520	2007	\$1,000
1991	\$540	2008	\$1,050
1992	\$570	2009	\$1,090
1993	\$590	2010	\$1,120
1994	\$620	2011	\$1,120

To calculate the number of quarters for a year, divide the person's total earnings for the year by the amount needed to get one credit.

For earnings from employment, use the gross amount of earnings. For earnings from self-employment, use the amount of earnings after allowable self-employment expenses have been deducted.

Use only full quarters. Example: 2.95 quarters are rounded down to two quarters. Each person can have no more than four quarters per year. Example:

An alien earned \$5,000 gross income in 1995. ($\$5,000$ divided by $\$630 = 7.936$) Although the result equals over 7 quarters, the alien is credited with 4 qualifying quarters in 1995.



NOTE: Starting with January 1, 1997, do not count the income from any quarters in which an alien received any type of federal means-tested public assistance during the quarter. The quarters in a calendar year are: January through March, April through June, July through September, and October through December.

“Means-tested public assistance” includes FIP, SSI, Medicaid, and Food Assistance. Medicaid received by an individual, household, or family eligibility unit is receiving “means-tested public assistance.”

This means if an alien got FIP, Food Assistance, Medicaid, or SSI in June 1997, you would subtract the person’s April, May, and June earnings from the total 1997 earnings and divide the remainder to figure how many qualifying quarters the person has.

Aliens can count their spouse’s quarters earned during the marriage in addition to their own quarters in order to meet the 40-quarter requirement. Use the same formula to calculate qualifying quarters earned by a parent or spouse.

For example, if each spouse had 20 quarters you would add the quarters together and the wife would be eligible for IFPN.

Mr. and Mrs. Q are working in 2004. One earned \$25,000 gross income and the other earned \$3,000 gross income. ($\$25,000$ divided by $\$900 = 27.77$) ($\$3,000$ divided by $\$900 = 3.33$)

27.77 is converted to four quarters. 3.33 is converted to three quarters. The Qs’ countable quarters are combined together to determine the qualifying quarters. Mrs. Q is credited with seven qualifying quarters for 2004.

Count the spouse’s quarters earned during the marriage if the spouse is either a citizen or an alien, and either:

- ◆ The couple is currently married, or
- ◆ The couple is separated but not divorced, or
- ◆ A spouse is deceased and the surviving spouse is not remarried.

If the couple divorces, the former spouses are no longer entitled to each other’s quarters. Thus, if the divorce results in the alien no longer having 40 qualifying quarters, cancel the person’s IFPN.



Aliens can also count the quarters earned by a parent in addition to their own quarters to meet the 40-quarter requirement. For this policy, "parent" means the natural or adoptive parent or the stepparent. Count the parent's quarters if the parent:

- ◆ Is either a citizen or an alien and
- ◆ Earned the quarters before the child turned 21. (The parent's quarters earned before the child was born also count.)

Count the quarters by a stepparent during the stepparent relationship if the relationship still exists. Death of the stepparent does not end the relationship. Do not count quarters earned before the stepparent relationship began. Do not count any quarters of the stepparent if the parent and stepparent are divorced.

Do not count quarters earned by a child toward the eligibility of a parent.

(4) Sponsor Deeming

Legal reference: P. L. 104-193, P. L. 104-208, 20 CFR 416.1160(a), 416.1166a(d)3; 8 U.S.C. §§ 1182(a)(4), 1183a(1996); 441 IAC 75.11(3); 42 U.S.C. 1396b(v) as amended by P. L. 111-3

Aliens who seek admission to the United States as lawful permanent residents must establish that they will not become a "public charge." Many aliens establish that they will not become public charges by having "sponsors" who pledge to support them. An alien may have more than one sponsor.

A sponsor is a person who signs an "affidavit of support" agreeing to support an alien to help the alien obtain lawful permanent resident status. There are three versions of the *Affidavit of Support*:

- ◆ Form I-864. This form is enforceable since December 19, 1997.
- ◆ Form I-134. This form is not enforceable.
- ◆ Form I-361. This form is enforceable and must be submitted with a petition for treatment as an Amerasian. However, deeming will not apply to persons with type of support affidavit.



Sponsor deeming is the process of considering the income and resources of the sponsor to be available to the sponsored person, whether or not the income or resources are actually made available. The sponsor deeming rules apply **only** to persons who:

- ◆ Are lawful permanent residents (LPRs) aged 21 or over,
- ◆ Applied for lawful permanent resident status on or after December 19, 1997, and
- ◆ Are sponsored by a person who signed Form I-864, *Affidavit of Support*.

NOTE: Sponsor deeming may still affect IFPN eligibility of children under age 21 if an adult household member has a sponsor.

For deeming purposes, deeming will not apply when the sponsor is:

- ◆ An employer who does not sign an affidavit of support.
- ◆ An organization such as a church or service club.
- ◆ The alien's eligible or ineligible spouse or a parent whose income is otherwise considered in determining the alien's Medicaid eligibility.

If the eligible couple separates and begins living in separate households, then the sponsor-to-alien deeming rules apply.

(5) Verifying Qualifying Quarters

When an exception to sponsor deeming will affect the eligibility determination, the applicant or considered person is responsible for getting verification of qualifying quarters. This includes getting verification of the qualifying quarters earned by a spouse, parent, or stepparent.

In addition to verification from the Social Security Administration (SSA) office, you can use documentation such as:

- ◆ Wage stubs
- ◆ Employer's statement
- ◆ Income tax forms

If the alien does not have acceptable proof, the client is responsible for obtaining necessary verification from SSA. SSA can verify quarters starting with the year 1930.



If the alien provides verification from SSA of less than the required 40 qualifying quarters but disputes the SSA records, allow the alien an opportunity to resolve the discrepancy.

In either situation:

- ◆ Instruct the applicant in writing to obtain the necessary verification or proof of requesting the verification, or that SSA is investigating the discrepancy within ten days.

Include in the note that the alien will be denied if the requested verification is not received by the stated due date. Also ask that the applicant let you know if more time is needed to obtain the requested verification or proof of request for the verification.

- ◆ Deny the alien if you do not receive the requested verification or proof for requesting the SSA verification or investigation by the due date (or the extended due date, if applicable).

If the client provides the requested proof, pend the application until the SSA verification is received or the SSA investigation is completed. Periodically contact the client to check on the status of the SSA verification or investigation of the disputed qualifying quarters.

Process the IFPN application upon receipt of the SSA verification or the results of the completed investigation. Include the alien in the eligible group if SSA verifies at least 40 qualifying quarters.

If the completed investigation still verifies less than 40 qualifying quarters:

- ◆ Include the alien if the date of entry was before August 22, 1996.
- ◆ Deny the alien if the date of entry is on or after August 22, 1996.



(6) Alien Documentation Chart

Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Amerasians treated as refugees	<ul style="list-style-type: none">◆ Form I-551, <i>Permanent Resident Card</i> *◆ Temporary I-551 stamp in a passport◆ Form I-94, <i>Arrival/Departure Record</i>◆ Any verification from the USCIS or other authoritative document <p>All of these should have one of the following codes: AM-1, AM-2, AM-3, AM-6, AM-7, AM-8</p>	Eligible regardless of U.S. entry date
American Indians born outside the United States	<ul style="list-style-type: none">◆ Member of a federally recognized Indian tribe as defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act; or◆ Form I-551, <i>Permanent Resident Card</i>*, coded S1-3, born in Canada and at least 50% American Indian, to whom the provisions of section 289 of the Immigration and Nationality Act apply. <p>For the list of federally recognized tribes, refer to http://www.usdoj.gov/otj/resources.htm. A list of tribal government contacts is maintained at http://www.doj.gov/bia/docs/TLD-Final.pdf.</p>	Eligible regardless of U.S. entry date



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Asylee	<ul style="list-style-type: none">◆ Form I-94, <i>Arrival/Departure Record</i>, or passport stamped "asylee" or section 208.◆ Order granting asylum issued by the USCIS, an immigration judge, the Board of Immigration Appeals, or a federal court.◆ Forms I-688B or I-766, <i>Employment Authorization Document</i>, coded 274a.12(a)(5) or A5(a)10 or (a)3.◆ <i>Refugee Travel Document</i> (Form I-571) along with another card identifying status.◆ Any verification from the USCIS or other authoritative document. <p>NOTE: If adjusted to lawful permanent resident status, Form I-551, <i>Permanent Resident Card</i>, may be coded AS-6, AS-7, or AS-8.</p>	Eligible as of date asylum is granted



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<p>Battered alien (cannot live with abuser)</p>	<ul style="list-style-type: none"> ◆ Receipt or proof of filing visa petition Form I-130, <i>Petition for Alien Relative</i>, under immediate relative (IR) or second family preference (P-2) showing status as spouse; ◆ Form I-360, <i>Petition for Amerasian, Widow(er), or Special Immigrant</i>, (application to qualify as abused spouse or child under Violence Against Women Act); ◆ Form I-797, <i>Notice of Action</i>, referencing pending Form I-130, <i>Petition for Alien Relative</i>, or Form I-360, <i>Petition for Amerasian, Widow(er), or Special Immigrant</i>, or finding establishment of a prima facie case; ◆ Receipt or other proof of filing Form I-485, <i>Application to Register Permanent Residence or Adjust Status</i>, (application for adjustment of status on basis of an immediate relative or family second preference petition or Violence Against Women Act application); ◆ Form I-688B or I-766, <i>Employment Authorization Document</i>, coded 274a.12(a)(10) or A10 (applicant for suspension of deportation) or 274a 12(c)(14) or C14 (individual granted deferred action status); 	<p>Children under age 21, eligible regardless of U.S. entry date.</p> <p>NOTE: Continued battered alien status must be verified at each annual review.</p> <p>Adults (age 21 and over):</p> <ul style="list-style-type: none"> ◆ Barred for five years if entered United States on or after 8/22/96 ◆ Eligible if entered United States before 8/22/96 <p>See 8-L, Battered Aliens, for more information.</p>



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<p>Battered alien (cannot live with abuser) (Cont.)</p>	<ul style="list-style-type: none"> ◆ Any documents indicating a pending suspension of deportation or cancellation of removal case, including a receipt from an immigration court indicating filing of Executive Office for Immigration Review: <ul style="list-style-type: none"> • Form EOIR-40, <i>Application for Suspension of Deportation</i> or • Form EOIR-42, <i>Application for Cancellation of Removal</i>; or ◆ Any verification from the USCIS or other authoritative document. 	
<p>Conditional entrants (not used since 1980)</p>	<ul style="list-style-type: none"> ◆ I-94, <i>Arrival/Departure Record</i>, or other document indicating status as "conditional entrant," "Seventh Preference" Section 203(a)(7), or P7, or ◆ Any verification from the USCIS or other authoritative document. 	<p>Eligible because entered the United States before 8/22/96</p>
<p>Cuban or Haitian entrants (treated as refugees)</p>	<ul style="list-style-type: none"> ◆ Form I-94, <i>Arrival/Departure Record</i>, with a stamp indicating "Cuban/Haitian entrant" (rare; not used since 1980), any notation indicating "parole," or any documents indicating pending exclusion or deportation proceedings; 	<p>Eligible regardless of U.S. entry date</p>



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<p>Cuban or Haitian entrants (treated as refugees) (Cont.)</p>	<ul style="list-style-type: none"> ◆ Any documents indicating a pending asylum application, such as a receipt from the USCIS indicating filing of Form I-589, <i>Application for Asylum and for Withholding of Removal</i>; ◆ Forms I-688B or I-766, <i>Employment Authorization Document</i>, coded 274a.12(c)(8) or CI; or ◆ Any verification from the USCIS or other authoritative document. <p>NOTE: Persons who have adjusted to lawful permanent resident status may have Form I-551, <i>Permanent Resident Card</i>, coded with CH-6, CU-6, CU-7, LB-2, LB-6, or LB-7.</p>	
<p>Deportation or removal withheld</p>	<ul style="list-style-type: none"> ◆ Form I-94, <i>Arrival/Departure Record</i>, or passport stamped "section 243(h)" or "section 241(b)(3)"; ◆ Order granting withholding of deportation or removal issued by the USCIS, an immigration judge, the Board of Immigration Appeals, or a federal court; ◆ Forms I-688B or I-766, <i>Employment Authorization Document</i>, coded 274a.12(a)(10) or A10; ◆ Form I-571, <i>Refugee Travel Document</i>, with another card showing status; ◆ Any verification from the USCIS or other authoritative document. 	<p>Eligible regardless of U.S. entry date</p>



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<p>Iraqi or Afghan special immigrants (Lawful permanent residents, treated as refugees)</p>	<ul style="list-style-type: none"> ◆ Form I-551, <i>Permanent Resident Card*</i>, showing Iraqi or Afghan nationality with any of the following status codes: <ul style="list-style-type: none"> • SI1, SI2, SI3, SI6, SI7, SI9, or • SQ1, SQ2, SQ3, SQ6, SQ7, SQ9 ◆ Iraqi or Afghan passport with an immigrant visa stamp noting admitted under a status code listed and date of entry noted on passport or Form I-94, <i>Arrival/Departure Record</i>. 	<p>Eligible regardless of U.S. entry date</p>
<p>Lawfully residing immigrants or nonimmigrants</p>	<ul style="list-style-type: none"> ◆ Form I-94, <i>Arrival/Departure Record</i>; ◆ Forms I-688B or I-766, <i>Employment Authorization Document</i>; or ◆ Any verification from the USCIS or other authoritative document. <p>NOTE: The specific section of the law or a designation by USCIS must appear on the document indicating the alien is in one of the statuses listed following the definition of "lawfully residing"</p>	<p>Children under age 21, eligible regardless of U.S. entry date.</p> <p>NOTE: Continued lawfully residing status must be verified at each annual review.</p> <p>Adults age 21 and over, ineligible regardless of U.S. entry date.</p>



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<p>Lawful permanent residents (LPRs)</p>	<ul style="list-style-type: none"> ◆ Form I-551, Permanent Resident Card; * <p>NOTE: Form I-551 annotated with certain codes indicates the person originally entered the United States under another status and later adjusted to lawful permanent resident. Eligibility for these persons must be determined based on the original status upon entry. These statuses and codes are:</p> <ul style="list-style-type: none"> • Amerasian (AM-1, AM-2, AM-3, AM-6, AM-7, AM-8), • Asylee (AS-6, AS-7, AS-8), • Canadian-born American Indian (S1-3), • Cuban or Haitian (CH-6, CU-6, CU-7, LB-2, LB-6, LB-7), • Parolee (LA), or • Refugee (R8-6, RE-6, RE-7, RE-8, RE-9). <ul style="list-style-type: none"> ◆ Form I-327, Permit to Reenter the United States; ◆ Form I-94, Arrival/Departure Record, with a temporary I-551 stamp; ◆ Foreign passport stamped showing temporary evidence of lawful permanent resident or I-551 status; ◆ Form I-181, Memorandum of Creation of Lawful Permanent Residence, with approval stamp; 	<p>Children under age 21, eligible regardless of U.S. entry date. NOTE: Continued LPR status must be verified at each annual review.</p> <p>Adults (age 21 and older) with proof of 40 qualifying quarters, eligible regardless of U.S. entry date</p> <p>Adults (age 21 and over) without 40 qualifying quarters:</p> <ul style="list-style-type: none"> ◆ Barred for five years if entered United States on or after 8/22/96 ◆ Eligible if entered United States before 8/22/96



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
<p>Lawful permanent residents (LPRs) (Cont.)</p>	<ul style="list-style-type: none"> ◆ Order issued by the USCIS, an immigration judge, the Board of Immigration Appeals, or a federal court granting registry, suspension of deportation, cancellation of removal, or adjustment of status; or ◆ Any verification from the USCIS or other authoritative document 	
<p>Parolees NOTE: Must have been paroled for at least one year</p>	<ul style="list-style-type: none"> ◆ Form I-94, <i>Arrival/Departure Record</i>, indicating "parole" or "PIP" or "212(d)(5)," or other language indicating parole status; ◆ Forms I-688B or I-766, <i>Employment Authorization Document</i>, coded A4 or C11 [274a.12(a)(4), 274a.12(c)(11)]; or ◆ Any verification from the USCIS or other authoritative document. ◆ If adjusted to lawful permanent resident status, may have Form I-551, <i>Permanent Resident Card*</i> (some may be coded LA). 	<p>Children under age 21, eligible regardless of U.S. entry date.</p> <p>NOTE: Continued parolee status must be verified at each annual review.</p> <p>Adults (age 21 and over):</p> <ul style="list-style-type: none"> ◆ Barred for five years if entered United States on or after 8/22/96 ◆ Eligible if entered United States before 8/22/96



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Refugees	<ul style="list-style-type: none">◆ Form I-94, <i>Arrival/Departure Record</i>, or passport stamped "refugee" or section 207;◆ Forms I-688B or I-766, <i>Employment Authorization Document</i>, coded 274a.12(a)(3) or A3;◆ Form I-571, <i>Refugee Travel Document</i>, with another card verifying status; or◆ Any verification from the USCIS or other authoritative document. <p>NOTE: If adjusted to lawful permanent resident status, Form I-551, <i>Permanent Resident Card</i>*, may be coded R8-6, RE-6, RE-7, RE-8 or RE-9.</p>	Eligible regardless of U.S. entry date
Veterans or active duty personnel (lawful permanent residents) (Includes some family members of these persons. See Aliens Exempt From Five-Year Bar.)	<ul style="list-style-type: none">◆ Form I-551, Permanent Resident Card; *◆ Form I-327, Permit to Reenter the United States;◆ Foreign passport stamped showing temporary evidence of lawful permanent resident or I-551 status;◆ Form I-181, Memorandum of Creation of Lawful Permanent Residence with approval stamp;	Eligible regardless of U.S. entry date



Alien Status	Acceptable Documentation of Alien Status	Medicaid Status
Veterans or active duty personnel (Cont.)	<ul style="list-style-type: none"> ◆ Order issued by the USCIS, an immigration judge, the Board of Immigration Appeals, or a federal court granting registry, suspension of deportation, cancellation of removal, or adjustment of status; or ◆ Any verification from the USCIS or other authoritative document. 	
Victims of Trafficking	<ul style="list-style-type: none"> ◆ Original certification letter for adults or letter for children issued by the Office of Refugee Resettlement (ORR) and validated by calling the trafficking verification line at (866) 401-5510 <p>NOTE: SAVE does not have information about a person's status as a victim of trafficking.</p>	Eligible only for 8 months from entry date in original ORR certification; eligibility may continue if ORR issues recertification
Other (legal or illegal)	The person is undocumented or presents documents that indicate the person's alien status is one other than those specifically listed under Aliens Subject to Five-Year Bar or under Aliens Exempt from Five-Year Bar .	Ineligible regardless of U.S. entry date

Documentation of alien status is issued by the U.S. Citizenship and Immigration Services (USCIS), part of the Department of Homeland Security. Older documents were issued by the Immigration and Naturalization Service (INS).



7. Supplying Information and Verification

Legal reference: 42 CFR 435.916, 441 IAC 76.2(249A)

The applicant must supply complete and accurate information needed to make appropriate entries into the Family Planning Waiver System so that initial and ongoing eligibility can be established.

If additional information is needed, give, mail, or fax a written request to the applicant. Inform the applicant in writing of the date the information is due and the consequences for failure to supply the requested information or verification.

The applicant must supply the information within ten calendar days of the day a written request is given, mailed, or faxed to the applicant. The ten-day period begins with the first day after the written request is issued. When the tenth day falls on a nonworking day or a legal holiday, extend the due date to the next working day for which there is regular mail service.

“Supply” means the requested information or verification is received by the specified date. Additional time for providing the information can be allowed when the applicant is making every effort to obtain the information but is unable to do so within the required time and notifies you about the problem.

Make the appropriate entry into the Family Planning Waiver System that reflects the failure of an applicant or client to supply the requested information or refuses to provide authorization to obtain it.

a. Reporting Changes

Legal reference: 42 CFR 435.916(b) and (c); 441 IAC 75.4(3)“c” and “h,” 75.57(1), 75.57(2), and 76.10(249A)

The client or someone acting on the client’s behalf must report the following:

- ◆ Health insurance starts or covers family planning services,
- ◆ There is a change in mailing or living address,
- ◆ The woman becomes pregnant, or
- ◆ The person is no longer capable of reproducing (e.g., had sterilization surgery, hysterectomy, vasectomy, etc.).



b. Acting on Changes

Legal reference: 441 IAC 75.1(41)"c"(5)

A person found to be income-eligible upon application or at the annual recertification shall remain income-eligible for 12 months regardless of any change in income or household size.

IFPN eligibility ends if any of the following occur. The person:

- ◆ Becomes pregnant;
- ◆ Is no longer capable of reproducing children;
- ◆ Moves from Iowa;
- ◆ Becomes enrolled in *hawk-i*;
- ◆ Gains Medicaid eligibility under another Medicaid coverage group; or
- ◆ Turns age 55. EXCEPTION: The age requirement does not apply to those who are eligible for IFPN due to a pregnancy ending while receiving Medicaid.

1. Ms. D is approved for IFPN in January. In March, Ms. D receives a promotion that results in her countable income being over 300% of the federal poverty level. Ms. D remains eligible for IFPN through December since her increased income is disregarded for the remainder of her 12-month certification period.
2. Mr. L is approved for IFPN in January because his countable income does not exceed 300% of federal poverty level for a household of two, Mr. L and his wife. Mr. L has countable income of \$2,000 and his wife has no income.

In May, Mr. L's wife moves out. Mr. L's income is now over the limit for a household size of one, but he continues to be eligible for IFPN for the remainder of the 12-month certification period.
3. Ms. B is approved for IFPN with a January–December certification period. Ms. B reports on October 5 that she moved to Illinois. Ms. B's IFPN eligibility is canceled effective November 1.
4. Ms. H, age 16, applies for IFPN and is approved effective April 1. In July, Ms. H's mother applies for *hawk-i* and Ms. H becomes eligible effective August 1. Ms. H must be given timely notice to end IFPN eligibility. FPW system will end IFPN no later than September 1.



8. Annual Recertifications

Legal reference: 441 IAC 76.7(249A)

Recertification is the process to establish a new certification period when the existing period is about to end. Form 470-4071, *Family Planning Medicaid Review*, will be system-generated to the IFPN member at least 30 days before the end of the certification period. Click [here](#) to see a sample of this form.

A person filing a timely form 470-4071, *Family Planning Medicaid Review*, and who is determined eligible, will have a new 12-month certification period established beginning with the month following the last month of the previous certification period.

If form 470-4071, *Family Planning Medicaid Review*, is not completed and received by the end of the certification period, the person must reapply, using form 470-2927 or 270-2927(S), *Health Services Application*, and be determined eligible in order to establish a new certification period. Eligibility does not continue if a review is not completed.

9. Help Desk

Family planning agencies and clinics under contract with the Department of Human Services can submit questions about the IFPN policy to Iowa Family Planning Network's help desk at IFPN@dhs.state.ia.us.

10. Services Covered

Services covered under the IFPN program are more limited than what is payable through other Medicaid coverage groups. Only services approved by the Centers for Medicare and Medicaid Services are payable. Services are payable when billed with an approved diagnosis listed below.

<u>Code</u>	<u>Description</u>
00851	Anesthesia, tubal ligation/transection
00952	Anesthesia for hysteroscopy
11975	Insertion of non-biodegradable drug, device or implant
11976	Removal of non-biodegradable drug, device or implant
11977	Removal with reinsertion of non-biodegradable drug, device or implant
36415	Venipuncture
36416	Drawing blood capillary
57170	Diaphragm or cervical cap fitting



<u>Code</u>	<u>Description</u>
57410	Pelvic examination under anesthesia
58300	Insertion of intrauterine device
58301	Removal of intrauterine device
58340	Catheterization & introduction of saline infusion sonohysterography (SIS) or hysterosalpingography
58565	Essure - female sterilization
58600	Ligation or transection of fallopian tubes abdominal or vaginal approach, unilateral or bilateral
58611	Ligation or transection of fallopian tubes, when done at the time of cesarean delivery or intra-abdominal surgery
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy with fulguration of oviducts (with or without transection)
58671	Laparoscopy with occlusion of oviducts (e.g., band, clip, Falope ring) Salpingectomy, complete/partial, unilateral/bilateral (separate procedure)
58700	
64435	Injection anesthetic agent, paracervical
72190	Radiologic exam, pelvis, complete, minimum of 3 views
74740	Hysterosalpingography; supervision and interpretation only
76856	Ultrasound, pelvic (non-obstetric) B-Scan or real time with image documentation; complete (Payable only with a family-planning-related diagnosis)
76857	Ultrasound, pelvic (non-obstetric) B-Scan or real time with image documentation; limited or follow-up (Payable only with a family-planning-related diagnosis)
81000	UA by regent strips
81001	UA, auto with scope
81002	UA, routine without microscopy
81003	UA, auto without scope
81025	Urine pregnancy test
82948	Glucose, blood, stick test
84703	Gonadotropin, qualitative (pregnancy test)
85004	Automated differential WBC count
85007	Differential WBC count
85013	Hematocrit
85014	Blood count, hematocrit
85018	Blood count, hemoglobin
85025	Automated hemogram
85027	Automated hemogram
86318	Immunoassay for infectious agent reagent strip



<u>Code</u>	<u>Description</u>
86592	Syphilis, qualitative (aka VDRL)
86593	Syphilis tests; quantitative
87088	Culture, presumptive pathogenic organisms, screening only
87102	Knickers test for yeast
87110	Culture, chlamydia
87205	Smear, gram stain
87205	Smear, primary source, with interpretation, routine
87210	Smear, primary source, with interpretation, wt mount
87211	Smear, primary source, with interpretation, wet/dry mount
87220	Koh test
87490	Infectious agent detection by nucleic acid, chlamydia
87491	Chlamydia trachomatis, amplified probe technique
87590	Infectious agent detection by nucleic acid; N. gonorrhea, direct probe technique
87591	Gonorrhea - amplified probe test
87621	HPV - amplified probe test
88141	Cytopathology pap, cervical or vaginal; any reporting system requiring interpretation by physician
88142	Cytopathology, cervical or vaginal, liquid preservative; automated prep, manual screen under physician supervision
88143	Cytopathology, cervical or vaginal, liquid preservative; automated prep, manual screen & rescreen under physician supervision
88147	Cytopathology-smears cervical or vaginal, screening by automated system under supervision of physician
88148	Cytopathology, smears cervical or vaginal, automated manual rescreening under physician supervision
88150	Cytopathology, slides-cervical or vaginal, manual screening under physician supervision
88152	Cytopathology, slides manual screen & computer assisted rescreen under physician supervision
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	Cytopathology, slides, cervical or vaginal; with manual screening & computer assisted rescreening using cell selection & review under physician supervision
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal (Bethesda System); manual screen & rescreen under physician supervision



<u>Code</u>	<u>Description</u>
88166	Cytopathology, slides, cervical or vaginal (Bethesda System); manual screen & computer-assisted rescreen under physician supervision
88175	Cytopathology, cervical or vaginal, liquid preservative, auto prep, automated screen & manual rescreen, under physician supervision
88302	Level II - surgical pathology gross & microscopic exam
96372	Therapeutic injection -- replaces 90772
99000	Handling and conveyance of specimen for transfer from a physician's office to a lab
99001	Handling and conveyance of specimen for transfer from patient to other than physician's office to a lab (distance may be indicated)
99002	Handling, conveyance and other service in connection with the implementation of an order involving devices when devices are fabricated by an outside lab but which items have been designated, and are fitted and adjusted by the attending physician
99201	New patient office or other outpatient visit
99202	New patient office or other outpatient visit
99203	New patient office or other outpatient visit
99204	New patient office or other outpatient visit
99205	New patient office or other outpatient visit
99211	Established patient office or other outpatient visit
99212	Established patient office or other outpatient visit
99213	Established patient office or other outpatient visit
99214	Established patient office or other outpatient visit
99215	Established patient office or other outpatient visit
99241	New or established patient office or other outpatient consultations
99242	New or established patient office or other outpatient consultations
99243	New or established patient office or other outpatient consultations
99244	New or established patient office or other outpatient consultations
99245	New or established patient office or other outpatient consultations
99383	Preventive medicine service, new pt, initial, late childhood
99384	Preventive medicine service, new pt evaluation, adolescent
99385	Preventive medicine service, new pt, 18-39 years of age
99386	Preventive medicine service, evaluate, 40-64 years
99393	Preventive medicine service, established patient, late childhood
99394	Preventive medicine service, established patient, adolescent
99395	Preventive medicine service, established patient, 18-39 years of age
99396	Preventive medicine service, 40-64 years of age
99402	Preventive medicine counseling, periodic or follow-up visit (approx 15 minutes) - family planning visit
99420	Administration and inter health risk assessment instrument



<u>Code</u>	<u>Description</u>
99420	Completion of Risk Assessment form
A4261	Cervical cap
A4266	Diaphragm
A4267	Condom, nonspermicidal
A4267	Condom, spermicidal
A4268	Female condom
A4269	Spermicidal suppositories
A4269	Contraceptive foam
A4269	Contraceptive jelly
A4269	Contraceptive sponges
A4269	Vaginal contraceptive film
A4932	Basal thermometer
E1399	Essure implant
J1055	Depo Provera
J3490	Doxycycline
J3490	Flagyl
J3490	Vaginal cream, e.g., Terazol
J3490	Unclassified drugs (Use for medications and injectables related to contraception services). J3490 requires the claim to include the NDC number.
J7300	Intrauterine device (IUD)
J7302	IUD - Levonorgestrel-release intrauterine contraception 52 mg (brand name Merena)
J7303	Contraceptive supply, hormone containing vaginal ring, each
J7304	Transdermal hormonal (Evra - patch)
J7307	Levonorgestrel (contraceptive) implants system, including implants and supplies (brand name Implanon)
J8499	Prescription drug, oral, non-chemotherapeutic, not otherwise specified (Use for oral medications related to contraception services). J8499 requires the claim to include the NDC number.
S4989	Progestasert IUD
S4993	Oral contraceptive, 21-day supply
S4993	Oral contraceptive, 28-day supply
S4993	Seasonale - Family planning clinics. Seasonale requires prior authorization when dispensed at a pharmacy.
T1013	Sign language or oral interpretive services
T1999	Supplies and materials provided by phys over and above normal service



These codes are payable if billed with an approved diagnosis code to reflect that services were received as part of a family planning visit.

<u>Code</u>	<u>Description</u>
V25.0	General counseling and advice
V25.01	Prescription of oral contraceptives
V25.03	Encounter for emergency contraceptive counseling and prescription
V25.09	Other family planning advice
V25.11	Insertion of intrauterine contraceptive device
V25.12	Initiation of other contraceptive measures
V25.13	Intrauterine device checking, reinsertion, removal
V25.2	Sterilization
V25.4	Surveillance of previously prescribed contraceptive methods
V25.40	Contraceptive surveillance unspecified
V25.41	Contraceptive pill
V25.43	Surveillance of implantable subdermal contraceptive
V25.49	Other contraceptive method
V72.4	Pregnancy exam or test
V72.40	Pregnancy exam or test, pregnancy unconfirmed
V72.41	Pregnancy exam or test, negative result
V72.42	Pregnancy exam or test, positive result
V72.81	Pre-operative cardiovascular exam
V76.2	Cervix (routine cervical Papanicolaou smear)

The following diagnoses are payable only if the claim also includes a V25.4, V25.40, V25.42, V25.43 or V25.49

<u>Code</u>	<u>Description</u>
V45.5	Presence of contraceptive device
V45.51	Intrauterine contraceptive device
V45.52	Subdermal contraceptive implant
V45.59	Other
996.3	Mechanical complication of genitourinary device, implant, and graft
996.32	Due to intrauterine contraceptive device



F. CMS-1500 CLAIM FORM AND INSTRUCTIONS

The table below contains information that will aid in the completion of the CMS-1500 claim form. To view a sample of this form on line, click [here](#).

The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	OPTIONAL. Check the applicable program block.
1a.	INSURED'S ID NUMBER	REQUIRED. Enter the member's Medicaid ID number found on the <i>Medical Assistance Eligibility Card</i> . It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	REQUIRED. Enter the last name, first name and middle initial of the member. Use the <i>Medical Assistance Eligibility Card</i> for verification.
3.	PATIENT'S BIRTHDATE	OPTIONAL. Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	CONDITIONAL. If the member is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the member as a result of a work or auto related accident. NOTE: This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	OPTIONAL. Enter the address and phone number of the patient, if available.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
6.	PATIENT RELATIONSHIP TO INSURED	CONDITIONAL. If the member is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	CONDITIONAL. Enter the address and phone number of the insured person indicated in field 4.
8.	PATIENT STATUS	OPTIONAL. Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	CONDITIONAL. If the member carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	CONDITIONAL. Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the yes and no boxes.
10d.	RESERVED FOR LOCAL USE	OPTIONAL. No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	CONDITIONAL. This field continues with information related to field 4. If the member is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	CONDITIONAL. If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check yes and enter payment amount in field 29. If you have received a denial of payment from another insurance, check both yes and no to indicate that there is other insurance, but that the benefits were denied. NOTE: Auditing will be performed on a random basis to ensure correct billing.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	OPTIONAL. No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	CONDITIONAL. Chiropractors must enter the date of the onset of treatment as month, day, and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	CONDITIONAL. Chiropractors must enter the current x-ray date as month, day, and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK...	OPTIONAL. No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	CONDITIONAL. Required if the referring physician does not have a Medicaid number.
17a.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
17b.	NPI	SITUATIONAL. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider. If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.
18.	HOSPITALIZATION DATES RELATED TO...	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	<p>REQUIRED. Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	TYPE OF SERVICE	OPTIONAL. No entry required.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. D	PROCEDURES, SERVICES OR SUPPLIES	<p>REQUIRED. Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. Do not list services for which no fees were charged.</p> <p>Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.</p>
24. E	DIAGNOSIS CODE	<p>REQUIRED. Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. Do not write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.</p>
24. F	\$ CHARGES	<p>REQUIRED. Enter the usual and customary charge for each line item. The charge must include both dollars and cents.</p>
24. G	DAYS OR UNITS	<p>REQUIRED. Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the <u>total minutes</u> of general anesthesia.</p>
24. H	EPSDT/FAMILY PLANNING	<p>CONDITIONAL*. Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.</p>
24. I	ID QUAL.	<p>LEAVE BLANK. The claim will be returned if any information is entered in this field.</p>
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	<p>LEAVE BLANK.</p> <p>REQUIRED. Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.</p>



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. K	RESERVED FOR LOCAL USE	CONDITIONAL. Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	OPTIONAL. No entry required.
26.	PATIENT'S ACCOUNT NUMBER	OPTIONAL. Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
27.	ACCEPT ASSIGNMENT?	OPTIONAL. No entry required.
28.	TOTAL CHARGE	REQUIRED. Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	SITUATIONAL. Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	REQUIRED. Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	REQUIRED. Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of the claim form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY...	OPTIONAL. Enter the name and address associated with the rendering provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
32a.	NPI	OPTIONAL. Enter the NPI of the facility where services were rendered.
32b.		LEAVE BLANK. The claim will be returned if any information is entered in this field.
33.	BILLING PROVIDER INFO AND PHONE #	REQUIRED. Enter the complete name and address of the billing provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. The address must contain the ZIP code associated with the billing provider's NPI. NOTE: The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, access imeservices.org .
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME...	REQUIRED. Enter the complete name and address of the billing physician or service supplier.
33a.	NPI	REQUIRED. Enter the ten-digit NPI of the billing provider.
33b.		REQUIRED. Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, access imeservices.org .

G. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.



- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.
- ◆ **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Relations Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.



2. Remittance Advice Samples and Field Descriptions

Two different remittance advice formats may be issued, depending on whether the claims are for members and items that are also covered by Medicare Part B.

To view a sample of the standard RA-1500 remittance advice on line, click [here](#). The fields are described as follows:

	Field Name	Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status



	Field Name	Field Description
R	Total Billed Amt.	Total billed amount of all claims within same claim type or status
S	Total Other Sources	Total third-party insurance payments within same claim type or status
T	Total Paid by Mcaid	Total dollar amount paid within same claim type or status
X	Copay Amt.	Total copayment amount within same claim type or status

1	Patient Name	Last, first name or initial of the member as shown on the Medical Assistance Eligibility Card
2	Recip ID	Member identification number (7 digits + letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Billed Amt.	Total billed amount on claim
5	Other Sources	Total "other sources" on claim (for example: TPL, spenddown)
6	Paid by Mcaid	Total amount paid by Iowa Medicaid on claim
7	Copay Amt.	Total member copayment on claim
8	Med Rcd Num	Medical record number or patient account number
9	EOB	Explanation of benefits denial reason code if entire claim denied (Full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.)
10	Line	Claim line number
11	Svc-Date	Date of service
12	Proc/Mods	CPT or HCPCS code and modifier billed
13	Units	Number of units billed
14	Billed Amt.	Billed amount on this line
15	Paid by Mcaid	Amount paid by Medicaid on this line
16	Copay Amt.	Copayment amount on this line
17	Perf. Prov.	Treating provider national provider identifier (NPI) number



Field Name		Field Description
18	S	<p>Source of payment. Allowed charge source codes are as follows:</p> <ul style="list-style-type: none"> A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
19	EOB	Explanation of benefits denial reason code



To view a sample of the Medicare Part B crossover remittance advice format on line, click [here](#). The fields are described as follows:

Field Name		Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> and check were released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Number of Claims	Total number of claims within same claim type or status
R	Mcare Paid Amt	Total Medicare payment within same claim type or status
S	Mcare Apprd	Total Medicare approved within same claim type or status
T	Deductible	Total deductible amount within same claim type or status



	Field Name	Field Description
U	Coins. Amt.	Total coinsurance amount within same claim type or status
V	Copay	Total copayment amount within same claim type or status
X	Mcaid Paid Amt	Total Medicaid payment within same claim type or status

1	Patient	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits + letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Mcare Paid Amt	Total paid by Medicare on claim
5	Mcare Apprd	Total amount Medicare approved
6	Deductible	Total Medicare deductible on claim
7	Coins Amt.	Total Medicare coinsurance on claim
8	Copay	Total Iowa Medicaid copayment on claim
9	Mcaid Paid Amt	Total amount paid by Medicaid on claim
10	Med Rcd Num	Medical record number OR patient account number
11	Line	Line number
12	Svc-Date	Date of service on line
13	Proc Mods	CPT or HCPCS code and modifier billed
14	Units	Number of units billed
15	Mcare Paid Amt	Medicare paid amount on line item
16	Mcare Apprd	Medicare approved amount on line item
17	Deductible	Medicare deductible amount on line item
18	Coins. Amt.	Medicare coinsurance amount on line item
19	Copay	Iowa Medicaid copayment on line item
20	Mcaid Paid Amt	Total amount paid by Medicaid on line



Field Name		Field Description
21	S	Source of payment. Allowed charge source codes are as follows: A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
22	EOB	Explanation of benefits denial reason code. A full description of denial can be found on the last page of the <i>Remittance Advice</i> statement.